

# Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives

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## INTRODUCTION

*No physician...considers his own good in what he prescribes, but the good of his patient; for the true physician is . . . not a mere moneymaker.*

—Plato, *The Republic*

Consider the following hypothetical.<sup>1</sup> Jane Doe, a thirty-four year-old wife and mother of two, visits her primary care physician complaining of

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1. The facts of this hypothetical are loosely based on the facts of an actual 1995 lawsuit. Although the case did not yield a published opinion, an account of the suit and the trial can be found in the following sources: Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 75-77 (1996); *California Jury Awards \$3 Million to Family of Deceased Cancer Patient*, BNA HEALTH CARE DAILY, Nov. 27, 1995, at D5; Paul Elias, *Doctors Negligent in Woman's Cancer Death, Jury Finds*, L.A. TIMES, Nov. 16, 1995, at A3; Paul Elias, *Trial No Longer a Managed Care Test Case*, L.A. TIMES, Nov. 10, 1995, at A3; David R. Olmos, *Cutting Medical Costs—Or Corners?*, L.A. TIMES, May 5, 1995, at A1.

abdominal and pelvic pain and rectal bleeding. Her physician performs a pelvic exam and finds a palpable mass. He thinks the mass is probably a fibroid tumor, a benign condition that poses few health risks. He orders an ultrasound to confirm the diagnosis. Although the results of the ultrasound are inconclusive, he stands by his initial diagnosis. Since fibroid tumors are often simply monitored rather than treated, he tells Doe to come back in six months. Doe is a little concerned that her physician is not 100% certain that the mass is a fibroid tumor, but she trusts him when he tells her that additional tests or referral to a specialist are unnecessary.

The pain and bleeding don't go away, and Doe goes back to her doctor two more times over the next four months. Finally, on her third visit, her doctor orders a barium enema x-ray. The x-ray shows that Doe has colon cancer. Colon cancer, if detected early, is highly treatable. The five-year survival rate can be as high as 80%. Doe was not so lucky. Less than two years after the diagnosis, she is dead.

Doe's health plan was paid for by her employer. In the late 1980s, Doe's employer became frustrated with the rapidly rising cost of traditional indemnity type insurance<sup>2</sup> and began looking into managed care.<sup>3</sup> The company finally decided to contract with a health

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2. Under traditional indemnity insurance, doctors are paid on a fee-for-service basis. A patient decides to see a doctor, the doctor bills the insurance company, and, in all but the rarest cases, the insurance company pays the doctor. This reimbursement system is called fee-for-service (FFS) because the doctor receives a fee for every service she performs. Physicians who are paid on a FFS basis have a strong incentive to perform as many services as the insurance company will pay for. According to some, "the FFS system of American medicine is the root of all the problems we face with high costs." PETER R. KONGSTVEDT, *THE MANAGED HEALTH CARE HANDBOOK* 139 (3rd ed. 1996). This is, of course, an oversimplification. Many other factors have contributed to the high costs of medical care in the United States, including the fear of malpractice, an increase in expensive new technologies, an aggressive medical culture, and the aging of the American population. See, e.g., VICTOR R. FUCHS, *THE FUTURE OF HEALTH POLICY* 159 (1993) (arguing that the increase in health care costs is driven by the practice of defensive medicine, i.e., performing services, primarily as protection against malpractice suits, which provide little or no benefit to patients); BARRY R. FURROW ET AL., *HEALTH LAW CASES, MATERIALS AND PROBLEMS* 662 (2d ed. 1991) (discussing how aging of the American population has contributed to a rise in health care costs); Peter Franks et al., *Gatekeeping Revisited—Protecting Patients From Overtreatment*, 327 NEW ENG. J. MED. 424, 424 (1992) (noting increased health care costs driven by fee-for-service medicine, fears of malpractice liability, the costs of new technologies, an aggressive medical culture, increased patient expectations, and an oversupply of specialists).

3. See GEORGE ANDERS, *HEALTH AGAINST WEALTH* 16-34 (1996) (describing a Fortune 500 company's switch to managed care after health care costs increased 39% in one particularly bad year, and discussing history of employer-provided health insurance); KAREN DAVIS ET AL., *HEALTH CARE COST CONTAINMENT* 104-08 (1990) (describing how the rising cost of health benefits in 1980s changed corporate attitudes and noting that cost containment measures moved quickly from being unacceptable to becoming standard practice).

maintenance organization (HMO)<sup>4</sup> to provide its employees' health care.<sup>5</sup> When Doe first enrolled in the HMO, she was given a list of the HMO's primary care physicians (PCPs)<sup>6</sup> and told to select one. All of her non-emergency health care had to be provided or approved by her PCP. If Doe needed care that the PCP could not provide, the PCP could refer Doe to a specialist. Her PCP also had to order or approve all diagnostic tests. Because PCPs control their patients' access to the rest of the health care system, they are often called gatekeepers.<sup>7</sup>

Although Doe had a vague notion of what managed care<sup>8</sup> was all about, she didn't know much about how managed care had revolutionized the way that physicians are paid.<sup>9</sup> Doe's HMO paid its

4. HMOs are health care organizations that finance and deliver specified health care services for their members. See KONGSTVEDT, *supra* note 2, at 34-35. Unlike traditional indemnity insurance plans, which reimburse patients or their health care providers for the costs of medical services after the fact, HMOs actually provide medical services to their members through affiliations with health care providers. See *id.*

5. Employers began turning to HMOs in the 1980s for one reason: to save money. Although there is some evidence that the gap may be narrowing, premiums for HMOs have consistently been lower than premiums for either conventional fee-for-service plans or other types of managed care plans. In 1997, for example, the average monthly family premium was \$503 for a conventional fee-for-service plan, \$444 for a plan that utilizes a preferred provider organization (PPO), and \$430 for an HMO. See HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 21 (1997-98). These cost savings did not go unnoticed. In 1980, 4% of the U.S. population was enrolled in an HMO. See DAVIS ET AL., *supra* note 3, at 141. By 1995, enrollment had risen to 21.7%. See HEALTH INSURANCE ASSOCIATION OF AMERICA at 59. HMO penetration is even higher—33% in 1997—among those who have employer-provided health insurance. See *id.* at 58.

6. Primary care physicians are generally physicians who specialize in family practice, internal medicine, or pediatrics. See KONGSTVEDT, *supra* note 2, at 87, 120. In order to give women better access to their OB/GYNs, some states have statutorily expanded the definition of a primary care physician. See, e.g., CAL. CODE REGS. tit. 10, § 1300.45 (1998) (defining primary care physician as a general practitioner, internist, pediatrician, obstetrician-gynecologist, or family practitioner).

7. See KONGSTVEDT, *supra* note 2, at 994.

8. The term managed care is broad and generally refers to any technique used to keep medical costs down by reducing medically unnecessary care and to ensure that medically necessary care is provided in the most cost effective way possible. Managed care organizations accomplish these goals by using a wide variety of techniques, including utilization review; promoting preventive medicine and earlier identification of disease; requiring pre-authorization or second opinions for certain procedures; and capitation and other financial incentives for providers and patients. Today, 98% of all health plans use at least one of these techniques. See HEALTH INSURANCE ASSOCIATION OF AMERICA, *supra* note 5, at 58.

9. There are three basic methods of compensating physicians: fee-for-service; salary; or capitation. Fee-for-service (FFS) compensation, along with the incentive it provides to overtreat, is described in note 2. The second compensation method, salary, is

PCPs on a capitated basis. Under capitation, the PCP receives a set amount per month for each patient.<sup>10</sup> In return for this capitation payment, the PCP is expected to provide all primary care services.<sup>11</sup> The PCP receives the same capitation payment for each patient, regardless of how much or how little care the patient actually receives. The PCP is thus put at financial risk that the cost of caring for a patient could exceed the capitation payment.<sup>12</sup> Proponents of capitation argue that this risk will make doctors more cost conscious, cut down on medically unnecessary care, and help lower medical costs.<sup>13</sup>

In addition to capitating the PCPs own services, many HMOs also put PCPs at financial risk for the costs of diagnostic tests or referrals to specialists. After all, the potential gains of capitation could quickly be lost if physicians ordered excessive tests or made excessive referrals.<sup>14</sup> Some HMOs require physicians to use their capitation payments to cover the costs of all tests and referrals.<sup>15</sup> Other HMOs use withholds and risk pools.<sup>16</sup> Under this method, a percentage of each capitation payment is withheld and pooled with withholds from other PCPs. The risk pool is then used to pay for diagnostic tests, referrals to specialists, and hospitalizations.<sup>17</sup> If there is money left in the pool at the end of the year, it is divided among the physicians.<sup>18</sup> Since each test or referral

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used primarily by staff model HMOs, which pay their physicians a salary to provide care to their members. Kaiser is probably the best known example of a staff model HMO. The third method, capitation, is described in this section of the Article.

10. See KONGSTVEDT, *supra* note 2, at 121-24 (defining capitation); see also DAVID W. LEE, AMERICAN MEDICAL ASSOCIATION, CAPITATION: THE PHYSICIANS' GUIDE (Mark J. Segal et al. eds., 1995). This Article's discussion of capitation relies heavily on both of these sources.

11. The contract between the HMO and the PCP will, or should, define precisely what primary care services the PCP is expected to provide. See LEE, *supra* note 10, at 14 (stressing importance of precisely defining services subject to capitation, and noting that "[s]implistic definitions such as 'primary care services within the physician's scope of practice' are too vague and may lead to future misunderstandings").

12. Some commentators call this type of risk "service risk" rather than "financial risk." It is called service risk because of the potential that the PCP will need to perform a high volume of services for the same capitation payment. The term financial risk, on the other hand, is limited to payment methods that actually place the PCP's income at risk. See KONGSTVEDT, *supra* note 2, at 124. In this Article, the term financial risk is used to refer to both types of risk.

13. See *id.* at 135 (noting HMOs use capitation because it "eliminates the FFS incentive to overutilize and brings the financial incentives of the capitated provider in line with the financial incentives of the HMO").

14. Most specialists are still paid on a fee-for-service basis rather than a capitated basis. See *id.* at 179-81.

15. See *id.* at 134 (explaining "full-risk" capitation).

16. See *id.* at 129-31.

17. See *id.* at 130-31.

18. Most HMOs track which doctors are making referrals, or authorizing hospitalizations and ancillary tests. In some HMOs, if an individual doctor's rate is too high, they do not share in what is left in the risk pool. See *id.* at 131. Note also that not

depletes the pool, the physician has an incentive to provide care in the most economical manner possible in order to recover some of the withheld money.

Jane Doe's HMO used a combination of both methods. Her PCP had to pay for the costs of all diagnostic tests, and a risk pool was used to pay for referrals to specialists. Unfortunately for Doe, neither her HMO nor her PCP had ever explained this complex payment system to her. If they had, she might have questioned her physician more thoroughly when he told her she didn't need additional tests or a referral to a specialist.

Doe's husband thinks that his wife was killed by greed. He believes that if his wife's physician had ordered the barium enema x-ray on her first visit, his wife would be alive today. He also believes that the physician dragged his feet in ordering the test because the cost came out of his own pocket. He says that if he and his wife had known about how her physician was paid, they would gladly have borne the cost of the \$250 x-ray themselves.

Stories like this are becoming increasingly common.<sup>19</sup> As of yet, there is no conclusive evidence that managed care financial incentives lead to an inappropriate under-treatment of patients or a lower quality of health care.<sup>20</sup> However, the public's perception seems to be that HMOs and their physicians are putting money before medicine, and, as one commentator has noted, "the public is prepared to view certain payment

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all HMOs use capitation or risk pools to pay for services not provided directly by the primary care physician. Some HMOs will pay for these services in other ways, but will give physicians incentives to control costs by offering them bonuses for meeting performance, cost, or utilization goals. *See id.* at 97.

19. *See, e.g.,* Michael Pulley, *Kaiser, Heal Thyself*, SAC. NEWS & REV., Apr. 30, 1998, at 15, 18 (reporting on two patients who believe that cost cutting compromised quality of care and describing treatment of some patients by HMOs as "health-care horror stories"); Michael Meyer & Andrew Murr, *Not My Health Care*, NEWSWEEK, Jan. 10, 1994, at 36-37 (recounting stories of two women who had to sue their HMOs to get coverage for bone marrow transplants to treat breast cancer); Daniel Q. Haney & Fred Bayles, *Paying a Price for Cost-Conscious HMO's*, L.A. TIMES, Jan. 28, 1990, at A3 (recounting stories of several patients who believe their physicians withheld care because of financial incentives).

20. *See, e.g.,* David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 161-66 (1995) (reviewing a number of studies on how financial incentives impact quality of care and concluding that the available data suggests financial incentives do not significantly compromise patient care). Note that although the source cited says that the available research does not show that financial incentives decrease quality of care, their potential to do so, along with anecdotal evidence provided by individual patients, provides reason for concern.

methods as bribes to ration care.”<sup>21</sup>

There is no shortage of ideas on how to deal with financial incentives. Proponents of financial incentives argue that such incentives can eliminate medically unnecessary care and help put a lid on rapidly rising health care costs;<sup>22</sup> proponents also argue that financial incentives can achieve these goals without sacrificing quality.<sup>23</sup> Critics fear that financial incentives will compromise patient care by causing physicians to put their own self-interest before the best interests of their patients.<sup>24</sup> Among critics, some argue that financial incentives should be prohibited,<sup>25</sup> while others argue that they should be regulated.<sup>26</sup>

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21. William M. Sage, *'Health Law 2000': The Legal System And The Changing Health Care Market*, 15 HEALTH AFFAIRS 9, 18 (1996); see also Robert W. Geist, *Incentive Bonuses in Prepayment Plans*, 291 NEW ENG. J. MED. 1306 (1974) (noting that all financial incentives have the goal of influencing physician's medical decisions for the benefit of the organization "paying the bribe").

22. See, e.g., Alain C. Enthoven, *Shattuck Lecture—Cutting Cost Without Cutting the Quality of Care*, 298 NEW ENG. J. MED. 1229, 1229-30, 1234 (1978) (stating that in any "economically rational health plan" physicians must accept responsibility for the use of resources, and that lower cost does not need to mean lower quality); Haney & Bayles, *supra* note 19, at A3 (reporting that proponents tout HMOs' ability to deliver cost-conscious medicine by financially incentivizing physicians to avoid unnecessary tests and treatment).

23. See, e.g., Franks et al., *supra* note 2, at 424-25 (arguing that financial incentives can actually improve quality of care by decreasing medically unnecessary care and iatrogenic complications associated with unnecessary care); DAVIS ET AL., *supra* note 3, at 203 (noting that, if physicians were provided with both better scientific knowledge and financial incentives, quality of care could increase at the same time health care costs decreased).

24. See, e.g., Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743, 1747 (suggesting that certain types of financial incentives may cause physicians to withhold too much care); Haney & Bayles, *supra* note 19, at A3 (noting that there is a worry that some financial incentives may be so strong they will tempt doctors to err in favor of doing too little).

25. See, e.g., Orentlicher, *supra* note 20, at 169-70 (noting that some commentators argue that financial incentives be prohibited entirely because "there is no objective method for defining 'too dangerous' an incentive, and the definition chosen may fall short of that needed to protect patient welfare"); Arnold S. Relman, *Dealing With Conflicts of Interest*, 313 NEW ENG. J. MED. 749, 751 (1985) (arguing that physicians be required to avoid "financial interests in medical marketplace"); Geist, *supra* note 21, at 1308 (recommending that federal and state governments outlaw financial incentives).

26. See, e.g., MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 146, 225 (1993) (detailing strength and weakness of different types of financial incentives, and recommending that some of the strongest ones be prohibited); Orentlicher, *supra* note 20, at 167-69 (recommending that financial incentives which have high potential for abuse be prohibited, and identifying such incentives by amount of risk borne by physician, whether incentives are tied to physicians individually or as group, and length of time over which performance is measured). The federal government has recently regulated the use of financial incentives by HMOs that have contracts to provide services to Medicare and Medicaid beneficiaries. See 42 C.F.R. §§ 417.479, 434.67 (1997) (requiring that physicians have stop-loss protection if the HMO places their income at substantial financial risk, and

This Article advocates disclosure as a compromise between wholeheartedly embracing financial incentives and flatly prohibiting them, and suggests using fiduciary law to compel such disclosure. This Article also argues that courts should recognize a cause of action for breach of fiduciary duty when a physician fails to disclose managed care financial incentives to her patients. Part I gives a brief overview of fiduciary law and fiduciary duties. Part II examines the fiduciary nature of the physician-patient relationship and looks at court cases that have characterized the physician-patient relationship as a fiduciary relationship. Part III discusses the only two published opinions that have addressed the issue of whether a patient can bring a breach of fiduciary claim against a physician. Building on these two cases, Part IV recommends that courts recognize a cause of action for breach of fiduciary duty for failure to disclose managed care financial incentives and discusses the remedies for breach. Finally, Part V examines the

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defining substantial financial risk as between 25-33% of physician's total income, depending on how risk is structured; also prohibiting HMOs from directly or indirectly using incentives to reduce or limit medically necessary services to individual patients). Stop-loss protection is a form of reinsurance that protects PCPs who are paid on a capitated basis. Once the costs of caring for an individual patient, or a group of patients, exceeds the stop-loss amount, the reinsurance kicks in and the physician will either be reimbursed for the excess costs, or the excess costs will not be counted against, and deducted from, the risk pool. *See KONGSTVEDT, supra* note 2, at 132. Several states have also passed or are considering legislation that would limit the types and amounts of financial incentives that HMOs can use. *See, e.g.,* TEX. INS. CODE ANN. art. 20A.14(l) (West Supp. 1998) (stating that HMOs may pay physicians on capitated basis, but prohibiting HMOs from using "any financial incentive or make any payment to a physician or provider that acts directly or indirectly as an inducement to limit medically necessary services"); H.B. 1843, 81st Reg. Sess. (Ak. 1997) (prohibiting health plans from using financial incentives to induce "less than medically necessary and appropriate care," stressing that nothing in the bill shall be deemed to prohibit capitation, and giving insurance commissioner authority to develop standards regarding financial incentives); S.B. 2602, 1997 Reg. Sess. (Miss. 1997) (requiring health plans to provide adequate stop-loss protection for physicians if they are placed at financial risk for services they do not actually provide, and directing department of insurance to develop standards of adequacy based on the number of physicians and patients in group); H.B. 2453, 182nd Gen. Ass., 1997-98 Reg. Sess. (Pa. 1998) (giving the secretary of health authority to prohibit incentives that "could have the capacity to lead to inadequate or poor quality care"); *see also* Geraldine A. Collier, *Chandler Touts Managed Care Bill; Measure Would Regulate HMOs*, TELEGRAM & GAZETTE, Sept. 11, 1997, at B1 (reporting on bill being considered by Massachusetts legislature that would limit financial incentives to 5% of doctor's salary); *HMO Disclosure Legislation: Slow Movement by States*, HEALTH LINE, Sept. 5, 1997 (noting that HMO disclosure laws being considered by states touch on "new, controversial area: the financial incentives HMOs provide doctors to limit or deny care").

benefits and limits of disclosure as a way of dealing with financial incentives.

I. WHAT IS A FIDUCIARY AND HOW DO I KNOW  
ONE WHEN I SEE ONE?

*No man can serve two masters: for either he will hate the one, and love the other; or else he will hold to the one, and despise the other.*

—Matthew, 6:24

The term fiduciary comes from the Latin word *fidere*, which means *to trust*.<sup>27</sup> The fiduciary concept originated in the law of trusts,<sup>28</sup> and trustees were probably the earliest fiduciaries.<sup>29</sup> A trustee is someone who takes title to property with the understanding that she will manage the property for the benefit of someone else, who is called the beneficiary.<sup>30</sup> This situation obviously creates a huge potential for abuse. How can the beneficiary stop the trustee from violating the trust by using the property for herself or absconding with the property?

Early common law courts were ill-equipped to deal with this situation. Since the trustee had title to the property, common law courts could offer the beneficiary no relief.<sup>31</sup> Ecclesiastical and equitable courts, however, found this situation intolerable. They were willing to enforce the trust and compel trustees to act faithfully.<sup>32</sup> The fiduciary concept

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27. See AMERICAN HERITAGE DICTIONARY 501 (2d College ed. 1985). The same Latin root also gave us *fidelis*, which means loyal, and *fides*, which means faith, trust, and fidelity. See FREDERIC M. WHEELLOCK, *LATIN 420* (3d ed. 1963).

28. See Ernest J. Weinrib, *The Fiduciary Obligation*, 25 U. TORONTO L.J. 1, 3 (1975); RODWIN, *supra* note 26, at 181.

29. Actually, the *feoffee to uses* were probably the earliest fiduciaries. See JESSE DUKEMINIER & STANLEY M. JOHANSON, *WILLS, TRUSTS, AND ESTATES* 564 (5th ed. 1995). The medieval *use*, which first appeared in England in the 13th century, is the ancestor of the modern trust. See *id.* The use was employed to get around laws mandating that all land descended to the eldest son (primogeniture) and laws prohibiting the clergy from owning property. See *id.* A use worked much like a trust. A landowner would convey legal title to land to a trustworthy person, called a feoffee to uses, with the understanding that the feoffee to uses would hold the land for the use and benefit of someone else, called the *cestui que use*. See *id.* The use was abolished in 1535 by the Statute of Uses, but was quickly replaced by the trust. See *id.* at 564-65.

30. See *id.* at 568; see also BLACK'S LAW DICTIONARY 1514 (6th ed. 1990) (defining trustee).

31. See DUKEMINIER & JOHANSON, *supra* note 29, at 564.

32. See *id.* (noting evidence that ecclesiastical courts may have enforced uses even before equity courts did); see also Tamar Frankel, *Fiduciary Law*, 71 Cal. L. Rev. 795, (1983) (noting ecclesiastical and equity courts were the first courts with jurisdiction over



was thus initially created to deal with the problem of disloyal trustees.

The fiduciary concept did not remain confined to the law of trusts for long. Courts soon found other relationships that shared many of the attributes of the trustee-beneficiary relationship. Reasoning by analogy, courts have applied fiduciary duties to agents,<sup>33</sup> attorneys,<sup>34</sup> executors and personal representatives,<sup>35</sup> corporate officers and directors,<sup>36</sup> partners,<sup>37</sup> majority shareholders in close corporations,<sup>38</sup> public officials,<sup>39</sup> union officers,<sup>40</sup> and pension fund managers.<sup>41</sup> In order to gain a better understanding of fiduciary law, the remainder of this section first looks at what distinguishes fiduciary relationships from other relationships, and then explores the kinds of duties that fiduciary relationships impose on the parties.

At its core, a fiduciary relationship is a relationship where one person, the fiduciary, is under a duty to act for the benefit of another, the beneficiary.<sup>42</sup> The foundation of the relationship is the beneficiary's

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fiduciaries, and that use was first enforced by ecclesiastical courts); Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 Duke L.J. 879, 880 (1988) (noting that equity would grant relief where common law courts would not). This history also explains why trusts are usually described as creating a legal interest in the trustee, which was enforceable at law, and an equitable interest in the beneficiary, which was enforceable at equity.

33. See, e.g., *SHV Coal, Inc. v. Continental Grain Co.*, 545 A.2d 917, 921 (Pa. Super. Ct. 1988).

34. See, e.g., *Doe v. Roe*, 681 N.E.2d 640, 645 (Ill. App. Ct. 1997).

35. See, e.g., *Hartlove v. Maryland Sch. for the Blind*, 681 A.2d 584, 593 (Md. Ct. Spec. App. 1996).

36. See, e.g., *Diamond v. Oreamuno*, 248 N.E.2d 910, 912 (N.Y. 1969).

37. See, e.g., *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928).

38. See, e.g., *Zahn v. Transamerica Corp.*, 162 F.2d 36, 42 (3d Cir. 1947).

39. See J. C. SHEPHERD, *THE LAW OF FIDUCIARIES* 32 (1981) (arguing that some public officials are fiduciaries because they are obliged to act for public's benefit, and citing case support).

40. See *id.* at 34 (citing *Gabauer v. Woodcock*, 594 F.2d 662, 672 (8th Cir. 1979)); see also Frankel, *supra* note 32, at 796 (citing *Steele v. Louisville & N.R.R. Co.*, 323 U.S. 192 (1944)).

41. See 29 U.S.C. § 1002(21)(A) (1994) (defining an ERISA fiduciary as anyone with discretionary authority or control over an employee pension plan); *Varity Corp. v. Howe*, 516 U.S. 489, 496 (1996) (noting that the common law of trusts governed the management of pension plans before ERISA).

42. See 36A C.J.S. *Fiduciary* § 3, at 381 (1961); RODWIN, *supra* note 26, at 181 (defining fiduciary as one who has a legal obligation to serve others). Note that some commentators use the term "entrustor" or "fiducie" to refer generically to the person to whom a fiduciary owes a duty. See RODWIN, *supra* note 26, at 181 (coining term "fiducie"); Frankel, *supra* note 32, at 800 n.17 (coining term "entrustor"). This article will use the term "beneficiary."

well-reposed trust and confidence in the fiduciary's integrity and fidelity.<sup>43</sup> Fiduciaries are expected to keep this trust by serving their beneficiaries loyally and in good faith. A fiduciary relationship is thus much more one-sided than the usual relationship between parties contracting at arms-length. In effect, when a court holds that a particular relationship is a fiduciary one, the court is saying that for reasons of policy or justice the relationship should not be governed solely by the morals of the marketplace.<sup>44</sup>

Inequality, dependence, and reliance are also classic characteristics of fiduciary relationships.<sup>45</sup> The inequality usually stems from the fiduciary's superior skills, intelligence, or knowledge.<sup>46</sup> However, the inequality can also stem from a mental or physical weakness on the beneficiary's part.<sup>47</sup> Because of this inequality, beneficiaries are dependent on fiduciaries and must rely on the integrity of the fiduciary's judgment, actions, and advice.

Once a court determines that a relationship is a fiduciary one, it will compel the fiduciary to act accordingly. The fiduciary's duty is the highest standard of duty implied by law.<sup>48</sup> Probably because of its beginnings in equitable and ecclesiastical courts, fiduciary law has always been heavily imbued with notions of morality and justice.<sup>49</sup> According to one commentator, the goal of fiduciary law is nothing less than to raise the "morality of the marketplace."<sup>50</sup> Once someone becomes a fiduciary, fiduciary law "places him in the role of a moral person and pressures him to behave in a selfless fashion."<sup>51</sup>

It is common to divide fiduciary duties into two classes: the duty of

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43. See 36A C.J.S. *Fiduciary* § 3, at 381 (1961).

44. See *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) (requiring that a fiduciary be held to something stricter than the morals of the marketplace).

45. See Frankel, *supra* note 32, at 800 (noting that a beneficiary is dependent on, and must rely on, the fiduciary).

46. See 36A C.J.S. *Fiduciary* § 3, at 384 n.44 (1961) ("Fiduciary relations exist when parties to a transaction do not meet on equality, one party having a full knowledge and the other not, and the latter places confidence in the former.").

47. See *id.* at 387 n.57 ("[T]here must exist a certain inequality, dependence, weakness of age, of mental strength, business intelligence, knowledge of the facts involved, or other conditions giving to one advantages over the other." (quoting *Yuster v. Keefe*, 90 N.E. 920, 922 (Ind. App. 1910))).

48. See *D.A.B. v. Brown*, 570 N.W.2d 168, 172 (Minn. Ct. App. 1997) (citations omitted); *FDIC v. Stahl*, 854 F. Supp. 1565, 1572 (S.D. Fla. 1994) (citations omitted); *Miller v. Keystone Ins. Co.*, 636 A.2d 1109, 1116 (Pa. 1994) (Cappy, J., dissenting); see also BLACK'S LAW DICTIONARY 625 (6th ed. 1990).

49. See Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1073 (1991) (noting that cases use language of "moral censure"); SHEPHERD, *supra* note 39, at 60 (noting that fiduciary theory is a moral one).

50. Weinrib, *supra* note 28, at 3.

51. Frankel, *supra* note 32, at 830.

loyalty and the duty of care.<sup>52</sup> Most commentators agree, however, that it is the duty of loyalty that distinguishes fiduciary duties from other legal duties.<sup>53</sup> A fiduciary owes his beneficiary a duty of "the finest loyalty."<sup>54</sup> In the words of Benjamin Cardozo:

Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A [fiduciary] is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior. . . . Uncompromising rigidity has been the attitude of courts of equity when petitioned to undermine the rule of undivided loyalty. . . . Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd.

Self-interest is antithetical to fiduciary relationships.<sup>56</sup> The biblical quote at the beginning of this section—that no man can serve two masters—is often used by courts to describe the fiduciary's duty of undivided loyalty to his beneficiary.<sup>57</sup> It is sometimes said that a fiduciary may not even enter a situation where a conflict of interest could arise.<sup>58</sup> However, it is probably more accurate to say that, when faced with a conflict between duty and self-interest, the fiduciary must act according to the duty.<sup>59</sup> At the very least, the fiduciary must disclose the conflict.

While most jurisdictions recognize a cause of action for breach of

52. See Tamar Frankel, *Fiduciary Duties as Default Rules*, 74 OR. L. REV. 1209, 1210 (1995); SHEPHERD, *supra* note 39, at 47.

53. See SHEPHERD, *supra* note 39, at 48-49 (calling duty of loyalty the essence of a fiduciary relationship, opining that duty of loyalty and fiduciary relationship are really one and the same, and arguing that duty of care is best governed by contract or tort law rather than fiduciary law); Cooter & Freedman, *supra* note 49, at 1074 (stating that the duty of loyalty is considered by some commentators as the essence of a fiduciary relationship).

54. *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928).

55. *Id.*

56. See Frankel, *supra* note 32, at 830 (contrasting the fiduciary duty of loyalty with situations between contracting parties, where self-interest is the norm).

57. See *United States v. Mett*, 65 F.3d 1531, 1538 (9th Cir. 1995); *Chapman v. Klemick*, 3 F.3d 1508, 1512 (11th Cir. 1993); *In re Estate of Shano*, 869 P.2d 1203, 1209 (Ariz. Ct. App. 1993); *Flatt v. Superior Court*, 885 P.2d 950, 956 (Cal. 1994); *SHV Coal, Inc. v. Continental Grain Co.*, 545 A.2d 917, 921 (Pa. Super. Ct. 1988).

58. See 76 AM. JUR. 2D *Trusts* § 380, at 375 (1992) (asserting that a fiduciary cannot enter into situations where his interests conflict with beneficiary's interests); 36A C.J.S. *Fiduciary* § 3, at 388 (1961) (stating that it is against public policy to let fiduciaries be placed in a position where selfish motives could lead them to betray the trust of a beneficiary).

59. See SHEPHERD, *supra* note 39, at 149.

fiduciary duty, the elements of this cause of action and the damages recoverable vary widely. In a majority of jurisdictions, the elements of breach of fiduciary duty are duty, breach, causation, and damages.<sup>60</sup> Some jurisdictions add a fifth element: lack of another recognized tort that encompasses the facts alleged.<sup>61</sup> In some jurisdictions, however, breach of fiduciary duty has just two elements: duty and breach. Courts in these jurisdictions hold that damages are not necessary because fiduciary duties are seen as prophylactic rules designed to protect beneficiaries by preventing wrongs before they happen.<sup>62</sup> These courts believe that even an unharmed plaintiff has a higher claim than the defendant to the proceeds derived from a breach of fiduciary duty.<sup>63</sup>

In light of fiduciary law's protective function, many courts have also created special rules to help plaintiffs in these cases. These special rules recognize the fact that the "law watches with the greatest jealousy transactions and dealings between persons occupying a fiduciary relationship."<sup>64</sup> For example, courts often reverse the normal rule that the plaintiff has the burden of proof in a civil case and hold that, once the plaintiff has shown that a fiduciary relationship exists, the defendant has the burden of disproving its breach.<sup>65</sup> Many courts also hold that the

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60. See *St. Paul Fire & Marine Ins. Co. v. Great Lakes Turnings, Ltd.*, 774 F. Supp. 485, 489-90 (N.D. Ill. 1991); *Stanley v. Richmond*, 41 Cal. Rptr. 2d 768, 776 (Ct. App. 1995); *FDIC v. Refco Group, Ltd.*, 989 F. Supp. 1052, 1080 (D. Colo. 1997).

61. See *Klemme v. Best*, 941 S.W.2d 493, 496 (Mo. 1997) (holding that if an alleged breach can be characterized as either negligence or breach of fiduciary duty, then the sole claim is negligence).

62. See *Milbank, Tweed, Hadley & McCloy v. Boon*, 13 F.3d 537, 543 (2d Cir. 1994) (noting breaches of fiduciary duty "comprise a special breed of cases that often loosen normally stringent requirements of causation and damages"); *Zackiva Communications Corp. v. Horowitz*, 826 F. Supp. 86, 88 (S.D.N.Y. 1993) (noting that it is "well established" that plaintiffs in breach of fiduciary duty cases need not allege damages); *Diamond v. Oreamuno*, 248 N.E.2d 910, 912 (N.Y. 1969) (noting that the absence of an "allegation of damages . . . has never been considered to be an essential requirement for a cause of action founded on a breach of fiduciary duty").

63. See *Diamond*, 248 N.E.2d at 912; see also *Rice v. Perl*, 320 N.W.2d 407, 411 (Minn. 1982) (noting that "law has traditionally been unyielding in its assessment of penalties when a fiduciary . . . has breached any of his obligations," and upholding the forfeiture of compensation where an attorney breached the fiduciary duty to a client even though the client could not prove actual injury).

64. *Henricks v. James*, 421 So. 2d 1031, 1042 (Miss. 1982).

65. See *Knaebel v. Heiner*, 663 P.2d 551, 553 (Alaska 1983) (holding existence of fiduciary duty justifies shifting the burden of proof to defendant); *Smith v. Tele-Communication, Inc.*, 184 Cal. Rptr. 571, 575 (Ct. App. 1982) (stating that where breach of fiduciary duty is alleged, the fiduciary has the burden of justifying his conduct); *Konover Dev. Corp. v. Zeller*, 635 A.2d 798, 810 (Conn. 1994) (holding proof of a fiduciary relationship imposes a double burden on the fiduciary: the burden of proof shifts to the fiduciary, and the standard of proof is clear and convincing evidence rather than preponderance of evidence); *Labovitz v. Dolan*, 545 N.E.2d 304, 311 (Ill. App. Ct. 1989) (noting that the fiduciary has the burden of proving by clear and convincing evidence that the transaction with the beneficiary is just and equitable and that all doubts

existence of a fiduciary relationship gives rise to a presumption of fraud or undue influence that can only be rebutted by clear and convincing evidence.<sup>66</sup> Finally, because of fiduciary law's origins, equitable remedies are available in breach of fiduciary duty cases.<sup>67</sup>

## II. THE PHYSICIAN AS FIDUCIARY

*The foundation of the patient-physician relationship is the trust that physicians are dedicated first and foremost to serving the needs of their patients.*

—Council on Ethical and Judicial Affairs,  
American Medical Association<sup>68</sup>

Numerous courts have recognized that physicians have most of the

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are resolved against the fiduciary); *Sampson v. Hunt*, 665 P.2d 743, 754 (Kan. 1983) (holding that "[w]here the fairness of a fiduciary transaction is challenged, the burden of proof is upon the fiduciary to prove by clear and satisfactory evidence that such transaction was fair"); *Gaynier v. Ginsberg*, 715 S.W.2d 749, 754 (Tex. Ct. App. 1986) (holding that where the plaintiff establishes the existence of a fiduciary relationship, the burden of proof shifts to the defendant to prove that the transactions with plaintiff were fair); *Wilkins v. Lasater*, 733 P.2d 221, 228 (Wash. Ct. App. 1987) (holding that the burden of proof is on the fiduciary to show no breach of loyalty was committed, and noting that all doubts will be resolved against the fiduciary).

66. See *Barbara A. v. John G.*, 193 Cal. Rptr. 422, 432 (Ct. App. 1983) (holding that the existence of a fiduciary creates the presumption of undue influence); *In re Estate of DeJarnette*, 677 N.E.2d 1024, 1029 (Ill. App. Ct. 1997) (holding that the presumption of fraud or undue influence arises whenever the fiduciary benefits by virtue of his fiduciary status); *W & W Equip. Co. v. Mink*, 568 N.E.2d 564, 573 (Ind. Ct. App. 1991) (holding that the law presumes fraud whenever the fiduciary attempts to benefit from a transaction with the beneficiary); *Henricks*, 421 So.2d at 1042-43 (holding presumption of undue influence arises where a fiduciary receives substantial benefit from dealing with a beneficiary); *Crawford v. Mindel*, 469 A.2d 454, 458 (Md. Ct. Spec. App. 1984) (holding that although plaintiff usually has burden of proving fraud, fraud may be presumed where a fiduciary relationship exists).

67. See *David Welsh Co. v. Erskine & Tulley*, 250 Cal. Rptr. 339, 344 (Ct. App. 1988) (holding equitable relief appropriate in breach of fiduciary duty case); *Rice*, 320 N.W.2d at 411 (attorney who breaches fiduciary duty to client forfeits right to compensation); RESTATEMENT (SECOND) OF TORTS § 874 cmt. b (1979) (noting that plaintiff in breach of fiduciary duty cases may elect either compensatory damages or restitutionary recovery).

68. Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Ethical Issues in Managed Care*, 273 JAMA 330, 331 (1995) [hereinafter AMA, *Ethical Issues in Managed Care*]

classic hallmarks of fiduciaries, and have characterized the relationship between a physician and a patient as a fiduciary relationship.<sup>69</sup> The physician-patient relationship is based on a trust that transcends arms-length transactions.<sup>70</sup> The patient trusts that the physician is devoted to the patient's best interests.<sup>71</sup> It is this trust that allows the patient to place her health and life in the physician's hands and to communicate openly with the physician about intimate bodily details.<sup>72</sup> Without this trust and the open communication that it fosters, the patient's diagnosis and treatment can be jeopardized.<sup>73</sup>

The physician-patient relationship is also an unequal relationship that is characterized by dependence and reliance. Physicians possess inherent power over their patients because of their superior medical knowledge. As described by one court:

[P]atients are generally persons unlearned in the medical sciences and . . . courts may safely assume the knowledge of patient and physician are not in parity. . . . [T]he patient, being unlearned in [the] medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process. . . .

The inequality in the physician-patient relationship also stems from patients' inherent weaknesses. Patients rely on physicians at particularly

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69. See, e.g., *United States v. Neufeld*, 908 F. Supp. 491, 500 (S.D. Ohio 1995); *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978); *Stafford v. Shultz*, 270 P.2d 1, 1 (Cal. 1954); *Simmons v. University of Chicago Hosps. and Clinics*, 642 N.E.2d 107, 111 (Ill. 1994); *Henkin, Inc. v. Berea Bank & Trust Co.*, 566 S.W.2d 420, 423 (Ky. Ct. App. 1978); *Warsofsky v. Sherman*, 93 N.E.2d 612, 615 (Mass. 1950); *Henricks*, 421 So. 2d at 1041; *Brandt v. Medical Defense Assocs.*, 856 S.W.2d 667, 670 (Mo. 1993); *Stigliano v. Connaught Lab., Inc.*, 658 A.2d 715, 720 (N.J. 1995); *Demers v. Gerety*, 515 P.2d 645, 649 (N.M. Ct. App. 1973); *Carson v. Fine*, 867 P.2d 610, 611 (Wash. 1994). But see *RESTATEMENT (SECOND) OF TRUSTS*, § 2 cmt. b (1959) (noting that "although the relationship between two persons is not a fiduciary relation, it may, nevertheless, be a confidential relation," and giving as an example the physician-patient relationship).

70. See *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972) (stating that a physician's obligation to patients transcends arms-length transactions); *Brandt*, 856 S.W.2d at 670 (recognizing that a physician occupies a position of trust); *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 797 (N.D. Ohio 1965) (noting that the relationship between physician and patient is one of trust and confidence).

71. See *Petrillo v. Syntex Labs., Inc.*, 499 N.E.2d 952, 961 (Ill. App. Ct. 1986) (holding that the patient is entitled to trust that a physician will protect the sanctity of the physician-patient relationship and act in the patient's best interests).

72. See *Hammonds*, 243 F. Supp. at 801 (noting the necessity that patients be totally frank with physicians, even if that means disclosing embarrassing information); *Wenninger v. Muesing*, 240 N.W.2d 333, 337 (Minn. 1976) (noting that trust between doctors and patients is essential to successful treatment); *Berry v. Moench*, 331 P.2d 814, 817 (Utah 1958) (noting that the physician-patient privilege is grounded on a notion that patients should be encouraged to disclose even embarrassing and intimate details that might have a bearing on diagnosis and treatment).

73. See *Hammonds*, 243 F. Supp. at 801 (noting that candor is necessary to the effective pursuit of health).

74. *Cobbs*, 502 P.2d at 9.

vulnerable times; they are usually sick, physically weak, worried about how their sickness will effect their lives, and scared about their prognosis.<sup>75</sup> Patients are thus forced to depend on physicians at a time when their health—sometimes even their life—hangs in the balance.<sup>76</sup>

The rise of managed care has affected the balance of power in the physician-patient relationship in another way. Primary care physicians who serve as gatekeepers control their patients' access to the entire health care system. Primary care physicians must authorize diagnostic tests, referrals to specialists, and hospital admissions. In today's managed care environment, the physician's control over the patient is almost total.

Medical codes of ethics also emphasize the physician's fiduciary status.<sup>77</sup> Professional ethics demand that a physician's first duty is to her patients<sup>78</sup> and that physicians must act as patient advocates.<sup>79</sup> Physicians are expected to place their patients' interests above all others and to avoid personal conflicts of interests that might jeopardize this loyalty.<sup>80</sup> Physicians cannot profit at their patients' expense, except to the extent of fees generated by medical services actually rendered.<sup>81</sup> Finally,

75. See Orentlicher, *supra* note 20, at 147.

76. See *id.*

77. Some codes do more than emphasize the physician's fiduciary status; some explicitly state that a physician is a fiduciary. See, e.g., AM. MED. ASS'N, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, REPORT A (I-86): CONFLICTS OF INTEREST 2 (1986), quoted in Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 246 (1995) [hereinafter Rodwin, *Strains in the Fiduciary Metaphor*].

78. See AMA, *Ethical Issues in Managed Care*, *supra* note 68, at 334; World Med. Ass'n Declaration of Geneva Adopted by the General Assembly of The World Med. Ass'n at Geneva, Switzerland, September 1948 (declaring that a doctor's first consideration must be the health of patients, and that a doctor owes patients complete loyalty), quoted in RODWIN, *supra* note 26, at 268-69.

79. See AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS (1957), quoted in RODWIN, *supra* note 26, at 270. The physician's role as "patient advocate" is interesting in light of the fact that the fiduciary nature of the attorney-client relationship is so well established.

80. See Rodwin, *Strains in the Fiduciary Metaphor*, *supra* note 77, at 246-47 (summarizing ethical opinions from the American Medical Association, the American College of Physicians, and the American College of Surgeons).

81. See AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS (1957), quoted in RODWIN, *supra* note 26, at 270. Interestingly, as one commentator has pointed out, this ethical canon would seem to prohibit all managed care financial incentives. See Geist, *supra* note 21, at 1306. This ethical canon has also found expression in numerous laws which prohibit fee splitting. Fee splitting refers to the practice of paying or charging a fee for patient referrals. For example, a diagnostic laboratory might agree to pay a physician \$15 for every patient the physician refers to the lab for x-rays. Fee

physicians must keep patient information confidential.<sup>82</sup>

Professional norms also reinforce the fiduciary nature of the physician-patient relationship. In the eyes of the medical community, the ideal physician-patient relationship is based on trust.<sup>83</sup> The very concept of a profession<sup>84</sup> implies many of the hallmarks of a fiduciary relationship, including service to others<sup>85</sup> and superior knowledge.<sup>86</sup> Indeed, some commentators view professionals as striking a bargain with society in which they promise to serve their clients loyally, competently, and with integrity in exchange for high status, freedom from competition, and self-regulation.<sup>87</sup>

With the rise of managed care in general, and the widespread use of financial incentives in particular, many argue that the fiduciary nature of the physician-patient relationship is being eroded.<sup>88</sup> While proponents of

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splitting is problematic for two reasons. First, fee splitting can increase health care costs if the provider who pays the referral fee passes that cost on to the patient or the insurer. Second, fee splitting can lead to the provision of unnecessary treatment if physicians are tempted to make referrals in order to earn the referral fee. Fee splitting is prohibited by numerous state and federal laws. See, e.g., 42 U.S.C. § 1320(a)-7b(b) (1994) (prohibiting anyone from receiving or paying any remuneration in exchange for referring Medicare or Medicaid patients to other providers); ALA. CODE § 34-24-360(10) (1997) (listing fee splitting as grounds for revoking physician's license); CAL. BUS. & PROF. CODE § 650 (Deering 1998) (prohibiting fee splitting); IDAHO CODE § 54-1814(8) (1998) (listing fee splitting as grounds for professional discipline); NEB. REV. STAT. § 71-148(3) (1996) (same); R.I. GEN. LAWS § 5-37-5.1(12) (1995) (same).

82. See AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS (1957), quoted in RODWIN, *supra* note 26, at 270; Hippocratic Oath, quoted in RODWIN, *supra* note 26, at 268.

83. See Ezekial J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323, 323-25 (1995) (noting further that "trust" is a composed of six factors: choice, competence, communication, compassion, continuity and the absence of a conflict of interest).

84. Although definitions vary, many agree that professions are high-status, knowledge-based occupations characterized by specialized knowledge, autonomy, authority over others, and altruism. See RANDY HODSON & TERESA A. SULLIVAN, *THE SOCIAL ORGANIZATION OF WORK* 287-94 (1990). Medicine is one of the classic professions, along with law and divinity. See *id.*; see also ELIOT FREIDSON, *PROFESSIONAL POWERS* 21-22 (1986).

85. See HODSON & SULLIVAN, *supra* note 84, at 293-94 (discussing professionals' altruism and service to others); see generally Geoff Mungham & Philip A. Thomas, *Solicitors and Clients: Altruism or Self-Interest?*, in *THE SOCIOLOGY OF THE PROFESSIONS* 131 (Robert Dingwall & Philip Lewis eds., 1983) (noting that solicitors must put their clients' interests over self-interest and act according to principles of altruism).

86. See HODSON & SULLIVAN, *supra* note 84, at 288-90 (noting true professions are characterized by esoteric knowledge that is important to the well-being of society); Steven Brint, *Eliot Freidson's Contribution to the Sociology of Professions*, 20 WORK AND OCCUPATIONS 266 (1993) (stating a major source of professional power are knowledge monopolies, which give professionals the ability to control how their work is accomplished and to control others' access to certain resources).

87. See Dietrich Rueschemeyer, *Professional Autonomy and the Social Control of Expertise*, in *THE SOCIOLOGY OF THE PROFESSIONS*, *supra* note 85, at 38, 41.

88. See, e.g., AMA, *Ethical Issues in Managed Care*, *supra* note 68, at 333 (noting



managed care can argue that financial incentives are necessary in order to curb the rising costs associated with fee-for-service medicine, opponents may argue that they threaten the physician's duty of loyalty by forcing the physician to consider personal financial interests when caring for patients. Opponents may also fear that these financial incentives will lead physicians to undertreat patients and deny medically necessary care.

Traditional malpractice law supplies a partial response to such fears. If a physician denies care which is medically necessary, the patient can file a malpractice suit. In the Jane Doe hypothetical, for example, Doe's husband could try to allege that the failure to perform additional tests or to refer his wife to a specialist fell below the appropriate standard of care. In many instances, however, malpractice law is an inadequate remedy. As one commentator has noted:

There is a grey area in medicine and tort law that emerges in situations where it is medically reasonable and defensible to . . . [withhold] care for a patient's condition. . . . Withholding care from patients in the grey area is likely to cause injury to some individuals. These are patients who in fact do need treatment even though they do not display enough symptoms to make the need for care readily apparent. Physicians who have no considerations other than the patient's health will likely treat these patients as a matter of caution. Physicians influenced by cost control procedures will elect not to treat them. Since it is not malpractice to withhold care, tort law is not a deterrent to the injuries that will result.

Assume that Jane Doe's physician can prove that the failure to perform additional tests did not violate the appropriate standard of care because colon cancer is rare in young adults with no family history of the disease and because Doe's symptoms did not indicate colon cancer.<sup>90</sup>

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that financial incentives to limit care may compromise a physician's duty to patients); Emanuel & Dubler, *supra* note 83, at 326 (noting managed care poses threats to the ideal physician-patient relationship).

89. Edward B. Hirshfeld, *Should Third Party Payors of Health Care Services Disclose Cost Control Mechanisms to Potential Beneficiaries?*, 14 SETON HALL LEGIS. J. 115, 139 (1990); see also DAVIS ET AL., *supra* note 3, at 203 (noting the inevitability that in any system which encourages physicians and hospitals to provide fewer services, some reductions in services will have little adverse effect on—and may even enhance—quality, while other reductions will result in a decrease in quality). Davis states that “[g]iven the fiscal incentives confronting HMOs, one would expect isolated instances of underprovision of care by HMOs even if HMOs as a whole provide high-quality care.” *Id.* at 216.

90. In the real case, Jane Doe's physicians alleged that she was “vague” in discussing her symptoms during her first visit. See Olmos, *supra* note 1, at A1. She stressed pelvic and abdominal pain, which is not a symptom of colon cancer, rather than

Malpractice law might leave Doe without a remedy, even though additional tests could have diagnosed her cancer much earlier, even though her physician would probably have ordered additional tests in the absence of financial incentives, and even though Doe would have been willing to pay for the tests herself. Malpractice law thus provides only a partial response to fears that financial incentives will lead to adverse outcomes.

Some commentators have suggested that the doctrine of informed consent provides another response to financial incentives.<sup>91</sup> The doctrine of informed consent is based on each person's right to control what happens to her body.<sup>92</sup> Because of this right, physicians have a duty to obtain their patients' informed consent to medical treatment.<sup>93</sup> In order for consent to be informed, physicians must give their patients information about their diagnosis and the risks of, and alternatives to, the recommended treatment.<sup>94</sup> Failure to disclose this information constitutes malpractice.<sup>95</sup> If an undisclosed risk actually materializes and harms the patient, the physician is liable.<sup>96</sup> Although such a claim has not yet been successful, a patient could argue that the existence of managed care financial incentives is one of the risks that a physician must disclose in order to obtain a patient's informed consent to medical treatment.

The problem with relying on informed consent is that a majority of courts measure the scope of the physician's duty to disclose against a professional standard. In these jurisdictions, physicians are only required to disclose risks that a reasonable medical practitioner would

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rectal bleeding, which is. *See id.*

91. *See* Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1840-47 (1995) (arguing informed consent could be used to compel physicians to disclose financial incentives).

92. *See* *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

93. *See id.* at 780-81.

94. *See id.* Note that the recommended treatment could also include a decision not to treat.

95. *See* *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972). When a physician performs a procedure which a patient has not consented to at all, the physician is liable for battery. *See id.*; *Canterbury*, 464 F.2d at 783.

96. *See* *Canterbury*, 464 F.2d at 790. Because it is a type of malpractice, a plaintiff in an informed consent case must prove both causation and damages. In order to prove causation, the plaintiff must show (1) that an undisclosed risk occurred, and (2) that a reasonable patient would not have consented to the treatment if they had been informed of the risk. *See id.*; *Gracia v. Meiselman*, 531 A.2d 1373, 1374 (N.J. Super. Ct. Law Div. 1987). Most courts have adopted an objective reasonable patient standard because of fears of self-serving testimony. *See Cobbs*, 502 P.2d at 11 (noting that because the undisclosed risk materialized at the time of trial, "it would be surprising if the [patient] did not claim that had he been informed of the dangers he would have declined treatment").

disclose in similar circumstances.<sup>97</sup> Since few, if any, physicians currently disclose financial incentives, informed consent will not be a helpful tool for dealing with financial incentives in a majority of jurisdictions. A minority of courts have rejected a professional standard in favor of a patient-based standard.<sup>98</sup> These courts require physicians to disclose all risks that a reasonable patient would find material in deciding whether to consent to treatment.<sup>99</sup> In these jurisdictions, it would be possible to argue that physicians must disclose financial incentives; most patients would find them material because of their potential to cloud a physician's judgment. However, even in jurisdictions that have adopted a patient-based standard of disclosure, it is unclear whether courts will extend the concept of treatment risks to include financial incentives.<sup>100</sup>

Even if a traditional malpractice claim or an informed consent claim were available, there are still several reasons why a plaintiff might prefer to bring a different cause of action, like breach of fiduciary duty. First, evidence of financial incentives will likely influence the jury's deliberations and make it easier for a plaintiff to win punitive damages.<sup>101</sup> It is simply more powerful to argue that withholding

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97. See, e.g., *Ritz v. Florida Patient's Compensation Fund*, 436 So. 2d 987, 990 (Fla. Dist. Ct. App. 1983); *Jones v. Malloy*, 412 N.W.2d 837, 842 (Neb. 1987).

98. See, e.g., *Canterbury*, 464 F.2d at 786 (holding that "a professional standard is at odds with the patient's prerogative to decide on projected therapy himself").

99. See *Canterbury*, 464 F.2d at 786-88; *Truman v. Thomas*, 611 P.2d 902, 905 (Cal. 1980); *Cobbs*, 502 P.2d at 11.

100. But see *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990) (holding that the patient could bring an informed consent claim against a physician for failure to disclose research or economic interests in patient's treatment that could affect physician's professional judgment). Given the *Moore* court's holding, it is entirely possible that, in California at least, a patient could state an informed consent claim against a physician for failing to disclose managed care financial incentives. It is unclear, however, whether other courts will follow *Moore*. The *Moore* court held that the failure to disclose research or economic interests in the patient's treatment could also give rise to a claim for breach of fiduciary duty; the decision is thus discussed in greater detail in Part III of this paper.

101. See, e.g., Christine Woolsey, *Jury Hits HMO for Coverage Denial*, BUS. INS., Jan. 3, 1994, at 1 (quoting lawyer who successfully sued HMO for breach of contract and breach of duty of good faith as stating that the jury, which awarded \$77 million in punitive damages, was astonished to learn of financial incentives); Elias, *Doctors Negligent in Woman's Cancer Death*, *supra* note 1, at A3 (quoting defense attorney as saying that the jury was unduly influenced by plaintiff's attorney's argument that physicians delayed in sending the woman to a specialist because they feared doing so would cut into their profits; jury returned \$3 million verdict against physician); *California Jury Awards \$3 Million to Family of Deceased Cancer Patient*, *supra* note 1

treatment was motivated by greed rather than by a failure to “use the care and skill ordinarily exercised in like cases by reputable members of the profession.”<sup>102</sup> However, in a malpractice case, where the focus is on whether the physician met the applicable standard of care, the court might exclude evidence of financial incentives as either irrelevant or overly prejudicial.<sup>103</sup> If she can get around this evidentiary barrier, the plaintiff might also want the court to instruct the jury on the fiduciary nature of the physician-patient relationship and the physician’s duty of loyalty. But courts rarely give fiduciary instructions in malpractice cases.<sup>104</sup> A plaintiff might also prefer a different cause of action in order to get around the limits on damages that many states have imposed on malpractice suits.<sup>105</sup> Finally, a plaintiff might want to take advantage of the availability of equitable remedies or of the shifting burdens of proof and special presumptions that courts have created in breach of fiduciary duty cases. Thus, even where a malpractice claim is available, a plaintiff might prefer to file a breach of fiduciary duty claim instead. Part III discusses the only two published opinions that have addressed the issue of whether a plaintiff may do so.

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(noting plaintiff’s lawyer presented evidence that capitation allowed doctors to profit by not sending patients to specialists). Note that punitive damages are rarely available in malpractice cases. See BARRY R. FURROW ET AL., HEALTH LAW § 6–7, at 261 (1995).

102. CALIFORNIA JURY INSTRUCTIONS—CIVIL: BOOK OF APPROVED JURY INSTRUCTIONS § 6.00.1 (Paul G. Breckenridge, Jr. ed., 8th ed. 1994 & Supp. 1998) (setting forth California’s standard medical malpractice jury instruction).

103. See *Madsen v. Park Nicollet Med. Ctr.*, 419 N.W.2d 511, 515 (Minn. Ct. App. 1988), *rev’d on other grounds*, 431 N.W.2d 855 (Minn. 1988) (holding that the trial court did not abuse discretion in excluding evidence of financial incentives because such evidence is only “marginally relevant, and potentially very prejudicial”).

104. But see *Demers v. Gerety*, 515 P.2d 645, 650 (N.M. Ct. App. 1973) (approving instruction on physician’s fiduciary duty in malpractice case), *rev’d on other grounds*, 589 P.2d 180 (N.M. 1978).

105. See, e.g., CAL. CIV. CODE. § 3333.2 (Deering 1984) (limiting noneconomic losses in medical malpractice suits to \$250,000); IND. CODE ANN. § 27-12-14-3 (Michie 1994) (limiting malpractice awards to \$750,000); VA. CODE ANN. § 8.01-581.15 (Michie 1992) (limiting malpractice awards to \$1 million); see also FURROW ET AL., *supra* note 2, at 392-95 (discussing other statutory reforms to malpractice law, including shortened statutes of limitations, alterations in plaintiffs’ burden of proof, and requirements that malpractice cases be pre-screened before proceeding to trial).

## III. SUITS AGAINST PHYSICIANS FOR BREACH OF FIDUCIARY DUTY

*Certainly a sick patient deserves to be free of any reasonable suspicion that his doctor's judgment is influenced by a profit motive.*

—California Court of Appeal<sup>106</sup>

As noted in Part II, numerous courts have held that physicians have fiduciary duties to their patients. But with two exceptions, none of these cases has involved an actual breach of fiduciary duty claim. Most of these cases have dealt with the physician's duty of disclosure or confidentiality and have involved informed consent,<sup>107</sup> the medical malpractice statute of limitations,<sup>108</sup> or the physician-patient privilege.<sup>109</sup>

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106. *Magan Med. Clinic v. California State Bd. of Med. Exam'rs*, 57 Cal. Rptr. 256, 262 (Ct. App. 1967). *Magan* involved a challenge to the constitutionality of a California law prohibiting physicians from owning interests in pharmacies. *Id.* at 256. The court upheld the law under deferential review, noting that the Legislature had reason to believe that a "doctor who has a financial interest in where his prescriptions are filled may be tempted to prescribe unnecessary medicine, or to prescribe a drug which yields a greater margin of profit or to keep a patient on drugs for an unnecessary period of time." *Id.* at 262.

107. *See Nelson v. Gaunt*, 178 Cal. Rptr. 167, 173 (Ct. App. 1981) (noting that informed consent theory is based on a physician's fiduciary duty of disclosure); *Gates v. Jensen*, 595 P.2d 919, 922 (Wash. 1979) (same).

108. The statute of limitations in a medical malpractice case generally begins to run when the plaintiff actually discovers an injury, or should have discovered it by using reasonable diligence. *See Stafford v. Shultz*, 270 P.2d 1, 7 (Cal. 1954). However, the statute will be tolled where the patient's failure to discover the injury is caused by the physician's failure to disclose facts that would enable the patient to do so. *See id.* at 8. It is the fiduciary relationship between the patient and the physician that excuses the patient from exercising greater diligence in ferreting out the existence of injury. *See id.*; *see also Sanchez v. South Hoover Hosp.*, 553 P.2d 1129, 1132 (Cal. 1976) (noting that the tolling rule is based on the fiduciary relationship between doctor and patient, and the fact that, apart from a doctor's disclosure, a patient has few methods of learning that an injury was caused by negligence).

109. *See Torres v. Superior Court of San Diego County*, 270 Cal. Rptr. 401, 403-04 (Ct. App. 1990) (holding that although a physician has a fiduciary duty of confidentiality, physician-patient privilege does not bar the treating physician from testifying for the defense where the privilege was waived by plaintiff's filing of malpractice suit); *Trujillo v. Puro*, 683 P.2d 963, 967-68 (N.M. Ct. App. 1984) (discussing fiduciary duty of confidentiality in analyzing physician-patient privilege).

Only one case, *Moore v. Regents of the University of California*,<sup>110</sup> has held that a patient can state a claim against a physician for breach of fiduciary duty.<sup>111</sup> The only other case to address this issue, *D.A.B. v. Brown*,<sup>112</sup> held that if the alleged breach occurred during the doctor's treatment, examination, diagnosis, or care of the patient, the patient's only claim was for medical malpractice.<sup>113</sup> This section discusses both cases, concludes that *Moore* is the better reasoned decision, and argues that it should be followed by other courts.

#### A. *Moore v. Regents of the University of California*

The facts of *Moore* are unique. John Moore was treated for leukemia by Dr. David Golde at the UCLA Medical Center.<sup>114</sup> The course of treatment included the removal of Moore's spleen and almost seven years of follow up therapy and monitoring.<sup>115</sup> Throughout the treatment, but unbeknownst to Moore, Golde was conducting research on Moore's blood cells.<sup>116</sup> Golde's research paid off. He eventually obtained a patent on a cell line made from Moore's T-lymphocytes and successfully negotiated agreements for its commercial development.<sup>117</sup> When Moore found out about this, he sued Golde for, among other things, breach of fiduciary duty.<sup>118</sup>

The gravamen of Moore's complaint was that Golde "failed to disclose the extent of his research and economic interests in Moore's cells before obtaining consent to the medical procedures by which the cells were extracted."<sup>119</sup> The court agreed and held that "a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."<sup>120</sup> The court based its holding on the fact that a physician

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110. 793 P.2d 479 (Cal. 1990).

111. *Id.* at 483.

112. 570 N.W.2d 168 (Minn. Ct. App. 1997).

113. *Id.* at 172. Although not directly on point, the Arizona Supreme Court in *Hales v. Pittman* refused to recognize a cause of action against a physician for breach of trust where battery or malpractice actions provided adequate remedies. *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978).

114. *See Moore*, 793 P.2d at 480.

115. *See id.* at 481. The follow up included withdrawing and performing tests on Moore's blood, skin, bone marrow, and sperm. *See id.* Although Moore lived in Seattle, Washington, Golde insisted that all tests be performed at the UCLA Medical Center. *See id.* Moore complied with Golde's directions, and made several trips to Los Angeles. *See id.*

116. *See id.*

117. *See id.* at 482.

118. *See id.*

119. *Id.* at 483.

120. *Id.*

who has a research or economic interest in a patient has "potentially conflicting loyalties," and that a patient has a right to know about the possibility that "an interest extraneous to the patient's health" might affect the physician's judgment.<sup>121</sup>

After determining that Moore did indeed have a cause of action, the court had to characterize it. The court held that Moore's cause of action could be characterized as either a breach of fiduciary duty or as the failure to obtain informed consent to medical treatment.<sup>122</sup> Although informed consent is a widely accepted theory, the *Moore* court was the first to recognize a cause of action against a doctor for breach of fiduciary duty. Perhaps aware that it was treading in uncharted territory, and also aware of the potential to stretch the fiduciary metaphor too far, the court made the following cautionary statement:

In some respects the term "fiduciary" is too broad. In this context the term "fiduciary" signifies only that a physician must disclose all facts material to the patient's decision. A physician is not the patient's financial adviser. . . . [T]he reason why a physician must disclose possible conflicts is not because he has a duty to protect his patient's financial interests,<sup>123</sup> but because certain personal interests may affect professional judgment.

Although the *Moore* court recognized a new cause of action, it did not give lower courts any guidance on its contours or how it might differ, if at all, from an informed consent action. A plaintiff in an informed consent case must generally allege four elements: a duty to obtain the patient's informed consent to treatment; breach of that duty due to a failure to disclose the risks, benefits, and alternatives to the treatment; causation; and damages. In order to prove causation, the plaintiff must show that, had the disclosure been made, a reasonable patient would not have given consent.<sup>124</sup> The majority opinion in *Moore* did not specify how a breach of fiduciary duty claim would compare.

The dissent in *Moore* appeared to believe that the elements of a breach

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121. *Id.* at 484.

122. *See id.* at 485.

123. *Id.* at 485 n.10.

124. *See Cobbs v. Grant*, 502 P.2d 1, 11-12 (Cal. 1972). There was no evidence that Moore would have declined the splenectomy if he had known of Golde's research, although he might have picked another doctor to perform it. However, after the surgery, Golde told Moore he needed periodic monitoring at UCLA, and Moore traveled from his home in Seattle to Los Angeles in order to allow Golde to conduct the monitoring. *Moore*, 793 P.2d at 481. There was thus some evidence that Moore would not have made the trip if Golde had made the required disclosure.

of fiduciary duty claim would be identical.<sup>125</sup> In a concurring opinion, however, Justice Broussard suggested that the causation element would be different. Broussard stated that a plaintiff alleging breach of fiduciary duty “should not be required to establish that he would not have proceeded with the medical treatment in question . . . but only that the doctor’s wrongful failure to disclose information proximately caused the plaintiff *some* type of compensable damage.”<sup>126</sup> Although Broussard did not elaborate on the causation element or on what types of damages might be recoverable, he did note that punitive damages would “clearly” be recoverable.<sup>127</sup>

While *Moore* certainly raises questions about the contours of a breach of fiduciary duty claim, the decision is a sound one. As discussed in Part II, numerous courts have recognized that physicians have most of the classic hallmarks of fiduciaries, and numerous courts have recognized that physicians have fiduciary duties of disclosure towards their patients. Although the undisclosed interests in *Moore* were research interests,<sup>128</sup> the court’s holding could easily be extended to managed care financial incentives. As the court noted, “the law . . . recognizes that a reasonable patient would want to know whether a physician has an economic interest that might affect the physician’s professional judgment.”<sup>129</sup> Like the research interests in *Moore*, managed care financial incentives create economic interests that may affect a physician’s professional judgment. A patient should be able to state a cause of action for breach of fiduciary duty against a physician who fails to disclose these financial incentives.

#### B. D.A.B. v. Brown

In contrast to *Moore*, the Minnesota Court of Appeals held in *D.A.B. v. Brown* that a patient could not state a claim against a physician for breach of fiduciary duty for conduct that related to examination, diagnosis, treatment, or care.<sup>130</sup> Dr. David Brown was a physician specializing in pediatric endocrinology.<sup>131</sup> Over the course of eight

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125. See *Moore*, 793 P.2d at 518-19 (Mosk, dissenting) (referring to breach of fiduciary duty and informed consent causes of action as, jointly, a nondisclosure cause of action, and stating that the plaintiff must prove the physician breached the duty to disclose and that there was a causal connection between injury and failure to disclose).

126. *Id.* at 500 (emphasis added).

127. *Id.*

128. Note that although Golde’s direct interest in *Moore* was a research interest, he also had an indirect financial interest because he stood to gain financially if his research paid off.

129. *Id.* at 483.

130. 570 N.W.2d 168, 172 (Minn. Ct. App. 1997).

131. See *id.* at 169.



years, he prescribed a drug called Protoprin to more than 200 patients.<sup>132</sup> Protoprin is used to treat growth hormone deficiency in children.<sup>133</sup> In 1994, Brown was indicted for violating the Medicare/Medicaid Anti-Kickback statute.<sup>134</sup> This statute prohibits physicians from receiving remuneration for referring Medicare or Medicaid patients to other health care providers.<sup>135</sup> The distributor of the drug was paying Brown to induce him to refer patients for Protoprin-related services and supplies.<sup>136</sup> Upon learning of the indictment, six of Brown's patients sued.<sup>137</sup> Their complaint was based on a breach of fiduciary duty for failing to disclose the kickback scheme; there was no allegation that the Protoprin treatment had been inappropriate or that they had been injured by the drug.<sup>138</sup> The trial court dismissed the suit for failure to state a claim, and the appellate court affirmed.<sup>139</sup>

The court started out by noting that lack of informed consent is a widely recognized cause of action against a doctor who fails to disclose material facts about treatment.<sup>140</sup> The court also acknowledged that the physician-patient relationship is a fiduciary one.<sup>141</sup> The court noted that it is "well accepted that patients deserve medical opinions about treatment plans and referrals unsullied by conflicting motives."<sup>142</sup> Finally, the court agreed that patients deserve medical advice that is free from "self-serving financial considerations."<sup>143</sup> However, the court refused to recognize the breach of fiduciary duty claim for failing to disclose these "self-serving financial considerations"; instead, the court held that all conduct related to the examination, diagnosis, treatment, or care of a patient should be governed solely by malpractice law.<sup>144</sup>

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132. *See id.*

133. *See id.*

134. *See id.* The Anti-Kickback statute is codified at 42 U.S.C. § 1320(a)-7b(b) (1994). It prohibits anyone from soliciting or receiving any remuneration in return for referring Medicare or Medicaid patients to health care providers or suppliers, or for purchasing or recommending any service or item for a Medicare or Medicaid patient. *See id.*

135. *See* 42 U.S.C. § 1320(a)-7b(b) (1994).

136. *See D.A.B.*, 570 N.W.2d at 169.

137. *See id.*

138. *See id.* at 169, 171.

139. *See id.* at 173.

140. *See id.* at 170.

141. *See id.* at 172.

142. *Id.* at 170.

143. *Id.* at 172.

144. *Id.* at 171.

The court gave only one reason for its decision. The court was worried that allowing these plaintiffs to bring a breach of fiduciary duty claim would allow plaintiffs generally to avoid the sometimes heavy burden of proving malpractice.<sup>145</sup> For example, there was no allegation that Brown was negligent in prescribing Protoprin and no allegation of injury. Both of these elements would have been required in a malpractice case, but not in a breach of fiduciary duty case.<sup>146</sup> The *D.A.B.* plaintiffs had also missed Minnesota's two-year statute of limitations for malpractice claims and were hoping to use the longer six-year statute applicable to general civil claims.<sup>147</sup> Since Brown's failure to disclose the kickback scheme presented a "classic informed consent" issue, and since the plaintiffs had not met the requirements of this malpractice claim, the court upheld the trial court's dismissal of their suit.<sup>148</sup>

Although the court's hesitancy to allow plaintiffs to avoid statutory malpractice requirements is understandable, its reasoning is flawed. The fact that the *D.A.B.* plaintiffs' case contained many of the elements of an informed consent claim should not have prevented them from being able to state a claim based on breach of fiduciary duty. The *D.A.B.* court failed to follow precedent on this issue set down by its own supreme court. In *Rice v. Perl*, the Minnesota Supreme Court recognized that, in the context of an attorney-client relationship, a client could have a cause of action for both malpractice and breach of fiduciary duty.<sup>149</sup> Cecilia Rice hired Norman Perl to represent her in a product liability suit against A.H. Robbins, the manufacturer of the Dalkon Shield, and Aetna Casualty & Surety, Robbins' insurer.<sup>150</sup> Perl negotiated a settlement with Willard Browne, an Aetna claims adjuster, and advised Rice to accept it.<sup>151</sup> However, Perl failed to disclose the fact that Browne was a good friend and that Browne had done occasional work for Perl's law firm.<sup>152</sup> When Rice discovered this undisclosed relationship, she sued Perl for malpractice and breach of fiduciary duty.<sup>153</sup>

The trial court dismissed the malpractice claim on summary judgment, holding that Rice had not sustained her burden of proving that the failure

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145. *See id.*

146. In Minnesota, damages are not an essential element of a breach of fiduciary duty claim. *See id.* at 172.

147. *See id.*

148. *Id.* at 171-73.

149. 320 N.W.2d 407 (Minn. 1982).

150. *See id.* at 408.

151. *See id.*

152. *See id.* at 409.

153. *See id.*

to disclose caused her any damages.<sup>154</sup> The trial court, however, granted Rice relief on the breach of fiduciary duty claim, holding that an attorney who fails to disclose material information to a client is guilty of breach whether or not damages are alleged.<sup>155</sup> Although Rice could not prove actual damages, the court held that Perl forfeited his attorney's fees because of the breach.<sup>156</sup> Both sides appealed, and the Minnesota Supreme Court affirmed.<sup>157</sup> Even though Rice was not able to state a claim for malpractice, she still had a viable breach of fiduciary duty claim.<sup>158</sup> The *D.A.B.* court should have followed *Rice* and allowed the breach of fiduciary duty claim to go forward even though a malpractice claim could not.

In addition to its failure to follow precedent, the *D.A.B.* decision is flawed for a second reason. Pleading in the alternative is a time-honored common law tradition, and many courts allow patients to sue their doctors on several different theories arising out of the same events. *Nelson v. Gaunt*,<sup>159</sup> a California Court of Appeal's decision, provides a good example of pleading in the alternative in a medical malpractice case. In 1968, Mary Nelson consulted Dr. Frank Gaunt about breast augmentation.<sup>160</sup> Gaunt told her about a safe and inexpensive procedure—silicone injection—that would be completely free of side effects.<sup>161</sup> Nelson consented to and had the procedure that day.<sup>162</sup> At the time, however, silicone was considered dangerous by the FDA and was not approved for non-scientific use.<sup>163</sup> Three months after the injection, Nelson discovered several lumps in her breast.<sup>164</sup> She consulted another

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154. *See id.* at 410.

155. *See id.*

156. *See id.*

157. *See id.* at 413.

158. Presumably, if Rice could have proven actual damages, she would have a viable claim for both malpractice and breach of fiduciary duty. *See also* Stanley v. Richmond, 41 Cal. Rptr. 2d 768, 776 (Ct. App. 1995) (noting that a professional negligence claim is different than a breach of fiduciary duty claim, and allowing both claims to proceed against an attorney); Klemme v. Best, 941 S.W.2d 493, 495-96 (Mo. 1997) (discussing the difference between malpractice and breach of fiduciary duty, and holding that, where an attorney's failure to disclose material information to a client does not fall below the professional standard of care, plaintiff can still state a cause of action for breach of fiduciary duty).

159. 178 Cal. Rptr. 167 (Ct. App. 1981).

160. *See id.* at 169.

161. *See id.*

162. *See id.*

163. *See id.* at 169-70.

164. *See id.* at 170.

physician who determined that the lumps were being caused by the silicone.<sup>165</sup> Not only could silicone itself be dangerous, but its presence made it difficult to detect whether the lumps were cancerous.<sup>166</sup> Three years later, her physician discovered a large mass in each breast and enlarged lymph nodes under her arms.<sup>167</sup> He recommended a double mastectomy, and Nelson agreed.<sup>168</sup> No malignancy was found, but Nelson was convinced she would eventually develop cancer.<sup>169</sup>

Soon after the surgery, Nelson sued Gaunt for malpractice, battery, fraud, and intentional infliction of emotional distress.<sup>170</sup> Gaunt moved for summary judgment on the grounds that the one-year statute of limitations for medical malpractice had run.<sup>171</sup> The trial court granted the motion with respect to the malpractice claim only.<sup>172</sup> The jury found for Nelson and awarded her \$2 million, including \$1.5 million in punitive damages.<sup>173</sup> Gaunt appealed and the appellate court affirmed.<sup>174</sup>

Gaunt argued that because all of Nelson's claims related to medical treatment they should all be controlled by the one-year medical malpractice statute of limitations.<sup>175</sup> The court disagreed, noting that battery, fraud, and intentional infliction of emotion distress were separate causes of action and were controlled by the three-year statute of limitations generally applicable in civil cases.<sup>176</sup> Gaunt had told Nelson that silicone was safe even though he knew the FDA considered it unsafe and even though injecting was actually illegal. The court held that Gaunt had a duty to disclose the true nature of the procedure to Nelson and that his intentional failure to do so could give rise to a cause of action for fraud, battery,<sup>177</sup> or intentional infliction of emotional distress.<sup>178</sup> The *Nelson* decision shows that the *D.A.B.* court's refusal to allow any cause of action other than malpractice is simply not persuasive.

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165. *See id.*

166. *See id.*

167. *See id.* at 170-71.

168. *See id.* at 171.

169. *See id.*

170. *See id.*

171. *See id.*

172. *See id.*

173. *See id.*

174. *See id.* at 179.

175. *See id.* at 171.

176. *See id.* at 173-74.

177. *See id.* at 173 (explaining that the procedure which Nelson consented to—a safe one with no side effects—was so different from the procedure that was actually performed, that jury could find the procedure performed amounted to battery).

178. *See id.* at 174.

IV. USING FIDUCIARY LAW TO COMPEL PHYSICIANS TO  
DISCLOSE FINANCIAL INCENTIVES

*Physicians today are experiencing ethical tensions between patient advocacy and population-based health care management.*

—William M. Sage<sup>179</sup>

Other courts should follow *Moore* and allow patients to state a claim against a physician for breach of fiduciary duty. While the outcomes in *Moore* and *D.A.B.* were different, there is one important similarity between the two cases that can help define the contours of the fiduciary duty at issue. *Moore* and *D.A.B.* were both disclosure cases. The plaintiffs filed suit because their physicians had not disclosed the fact that their treatment recommendations might be influenced by personal interests. The plaintiffs were not alleging that such personal interests in and of themselves gave rise to liability. In *Moore*, for example, the plaintiff was not arguing that physicians should not be allowed to have research interests in their patients, just that physicians should be required to disclose those interests. And in *D.A.B.*, the only claim against the doctor involved his failure to disclose the kickback arrangement, not the existence of the arrangement.<sup>180</sup> By focusing on nondisclosure and following the reasoning of *Moore*, courts should hold that physicians have a fiduciary duty to disclose managed care financial incentives.

Where a physician has breached the fiduciary duty of disclosure, a plaintiff should be able to elect either legal or equitable remedies. Where the failure to disclose causes actual damages to the plaintiff,<sup>181</sup> the plaintiff should be able to recover for those damages. In the Jane Doe hypothetical, for example, her husband could try to prove that if his

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179. 'Health Law 2000': *The Legal System and the Changing Health Care Market*, 15 HEALTH AFFAIRS 9, 11 (1996).

180. See *D.A.B. v. Brown*, 570 N.W.2d 168, 169 (Minn. Ct. App. 1997). Note that kickback schemes like the one in *D.A.B.* are prohibited under both Minnesota and Federal law. See *id.* at 170.

181. Actual damages in a breach of fiduciary claim would be similar to actual damages in medical malpractice claim, and would include lost wages, impaired earning capacity, medical expenses, and pain and suffering. See FURROW ET AL., *supra* note 101, at 261.

wife had known of the financial incentives she would have pressed her PCP or HMO harder, sought the advice of another physician, or paid for additional diagnostic tests on her own *and* that such actions would have led to an earlier diagnosis and a better chance of survival.<sup>182</sup> If Doe's husband can prove this, he should be able to recover for all damages flowing from the delayed diagnosis.<sup>183</sup>

Since breach of fiduciary duty is an equitable claim, plaintiffs should also be able to elect equitable remedies like restitution.<sup>184</sup> Courts have long held that restitution, particularly through the imposition of a constructive trust, is an appropriate remedy in breach of fiduciary duty cases.<sup>185</sup> With restitution, a plaintiff's recovery is measured by the benefit to the defendant rather than the harm to the plaintiff.<sup>186</sup> Because restitution is based on the principal that "a wrongdoer shall not be permitted to make a profit from his own wrong,"<sup>187</sup> some courts have held that restitution is available even where the plaintiff has suffered no

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182. Note that this causation analysis is similar to the analysis that is applied in informed consent cases. See *Gracia v. Meiselman*, 531 A.2d 1373, 1374 (N.J. Sup. Ct. Law Div. 1987) (holding that causation in informed consent cases is established by showing that the plaintiff would not have consented to treatment if the risk had been disclosed and the undisclosed risk materialized and harmed the patient).

183. Note that many jurisdictions recognize the loss of chance doctrine, whereby plaintiff can recover on a showing that the delay in diagnosis reduced their chance of survival, even where the chance of survival was below 50 percent to begin with. See *FURROW ET AL.*, *supra* note 101, at 262-64 (discussing "loss of a chance" doctrine). In *Herskovitz v. Group Health Cooperative*, 664 P.2d 474, 474 (Wash. 1983), for example, recovery was allowed where the physician's delayed diagnosis reduced plaintiff's chance of recovery from 39 percent to 25 percent. Thus, even if Doe's husband could not prove that his wife would have survived if her cancer had been diagnosed earlier, he would still be able to recover for the loss of chance caused by the delay.

184. See *Booher v. Frue*, 394 S.E.2d 816, 821 (N.C. Ct. App. 1990) (holding that a plaintiff in a breach of fiduciary duty case may elect either restitution or damages); RESTATEMENT (SECOND) OF TORTS § 874 cmt. b (1979) (noting that plaintiffs in breach of fiduciary duty cases are entitled to either tort damages or restitutionary recovery); see generally Douglas Laycock, *The Scope and Significance of Restitution*, 67 TEX. L. REV. 1277 (1989) (discussing the election of remedies).

185. See *Snepp v. United States*, 444 U.S. 507, 515 (1980) (holding that a constructive trust is a "natural and customary" remedy for breach of fiduciary duty); *Murges v. Bowman*, 655 N.E.2d 918, 923 (Ill. App. Ct. 1995) (holding that a constructive trust is an appropriate remedy for a breach of fiduciary duty); *Lyall v. Grayco Builders, Inc.*, 584 N.Y.S.2d 465, 471 (N.Y. App. Div. 1992) (same); *Meadows v. Bierschwale*, 516 S.W.2d 125, 128 (Tex. 1974) (noting that a breach of a fiduciary relationship justifies the imposition of a constructive trust); RESTATEMENT (SECOND) TORTS § 874 cmt. b (noting that the ordinary restitutionary remedy is the imposition of a constructive trust).

186. See *Edwards v. Lee's Adm'r*, 96 S.W.2d 1028, 1032 (Ky. Ct. App. 1936) (noting that restitutionary recovery is measured by "profits received, rather than by damages sustained"); Laycock, *supra* note 184, at 1287 (noting plaintiff will prefer restitution where defendant's gain exceeds plaintiff's loss, or where plaintiff's loss is difficult to prove).

187. *Edwards*, 96 S.W.2d at 1032.

harm.<sup>188</sup> Thus, even if a patient cannot prove they were harmed by their physician's failure to disclose financial incentives, the physician should not be allowed to keep the profits of her breach. As between the breaching physician and the innocent patient, the patient has a greater claim to those profits; a court should thus impose a constructive trust on the profits in favor of the plaintiff.

Here is one example of how the constructive trust remedy might work in a class action. Assume that an HMO withholds 20% of its PCPs' capitation rates and places this money in a risk pool that is used to pay for diagnostic tests and referrals to specialists. At the end of the year, whatever is left over in the pool is divided among the physicians. If a physician fails to disclose this financial incentive, a court would place a constructive trust on the money the physician received back at the end of the year. This amount would then be divided among patients based on a formula that took account of each patient's diagnosis, number of office visits, and treatment alternatives.<sup>189</sup>

Note that such a remedy comes close to imposing strict liability on a physician for failure to disclose. If the physician does not disclose the incentive, the physician must turn the fruits of the incentive over to the patient—period. It is important to point out, however, that this form of strict liability will not impose unfairly large burdens on physicians who

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188. See *id.* (noting that, in cases where plaintiff suffered no losses or unprovable losses, law, in seeking adequate remedy, "has been forced to adopt profits received, rather than damages sustained, as a basis of recovery"); *Snepp*, 444 U.S. at 507, 515 (imposing constructive trust on ex-CIA agent's book, where agent breached trust by publishing book without obtaining review by CIA, and noting that trust remedy simply requires wrongdoer to "disgorge the benefits of his faithlessness"); see also *supra* notes 62-63 and accompanying text (discussing the fact that damages are not always necessary in breach of fiduciary duty cases).

189. Note that the constructive trust remedy might be more attractive in class action cases than in individual cases because the amount available to any one plaintiff would not be great. In Jane Doe's case, for example, her recovery could conceivably be limited to the cost of the test that she claims her physicians profit-mindfully failed to order. In a class action, however, the recovery could be large enough to both deter physicians from failing to disclose and to attract the attention of plaintiffs' attorneys. A Texas attorney has recently filed a class action against several Texas HMOs for failing to disclose how they pay their physicians. See Charles Ornstein, *Harris Ready to End Suit; HMO Will Reveal Financial Incentives*, DALLAS MORNING NEWS, Feb. 3, 1998, at 1C. The attorney is representing a class of over one million patients, and is seeking restitution equal to the amount that the HMOs paid their physicians as financial incentives over the past six years. See *Harris Methodist: To Disclose Fee Arrangements*, HEALTH. LINE, Feb. 5, 1998. One of the defendants has recently agreed to disclose its physician payment arrangements in its member handbook. See *id.*

fail to disclose financial incentives. The most that a physician stands to lose is that portion of her salary that can be traced to the existence of the financial incentives. As the United States Supreme Court has said of the constructive trust remedy in a different context:

[i]t deals fairly with both parties by conforming relief to the dimensions of the wrong. . . . [If a fiduciary breaches a duty], the trust remedy simply requires him to disgorge the benefits of his faithlessness. Since the remedy is swift and sure, it is tailored to deter those who [would breach a fiduciary duty]. And since the remedy reaches only funds attributable to the breach, it cannot saddle the [fiduciary] with exemplary damages out of all proportion to his gain.<sup>190</sup>

Where a court finds that a physician has breached her fiduciary duty to disclose financial incentives, the court should use the constructive trust remedy to compel the physician to turn the fruits of those incentives over to her patients.

Note that some critics of financial incentives might argue that disclosure is not enough. These critics believe that financial incentives constitute an impermissible intrusion into the fiduciary relationship between physician and patient and should be prohibited altogether. In the words of one critic, "physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations . . . . When practicing medicine, doctors cannot serve two masters . . . . The doctor's master must be the patient."<sup>191</sup> To these critics, a breach of fiduciary duty can arise whenever a physician is tempted by a conflict of interest, regardless of whether the conflict is disclosed. Such a duty of absolute and undivided loyalty is imposed on certain fiduciaries, particularly trustees, who are usually prohibited from placing themselves in situations where conflicts of interest can arise.<sup>192</sup> However, imposing this type of strict obligation on physicians stretches the fiduciary metaphor too far. There are several reasons for limiting breach of fiduciary duty suits against physicians to cases involving nondisclosure.

First, limiting a breach of fiduciary duty claim to nondisclosure reflects the scope of the physician's fiduciary duty as outlined by the courts. As discussed in Part I, fiduciary law has evolved by analogy.

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190. *Snepp*, 444 U.S. at 515-16.

191. Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1575 (1984).

192. See, e.g., 90 C.J.S. *Trusts* § 248(a) (1955) (trustee prohibited "from placing himself in any position where his self-interest will, or may, conflict with his duties as trustee, or in a position where he will be exposed to the temptation of acting contrary to the best interests of the beneficiaries."); 60 CAL. JUR. 3D *Trusts* § 160 (1994) (trustee owes undivided loyalty to beneficiaries and cannot place himself in a position that would expose the trustee to temptation of acting contrary to the beneficiaries' best interests, irrespective of trustee's good or bad faith).



Over time, courts have held that new relationships have many of the same hallmarks as traditional fiduciary relationships. It would be a mistake, however, to think that just because a court finds that a particular relationship is a fiduciary one, it should be subject to the entire panoply of fiduciary duties. As discussed in Part II, almost all of the court cases that have discussed the fiduciary nature of the physician-patient relationship have focused on the physician's fiduciary duty of disclosure. Since this is the primary duty that courts have identified, this is the duty whose breach should give rise to a cause of action.<sup>193</sup>

Second, any outright prohibition or regulation of financial incentives should come from the legislature, not the courts. The few courts that have considered the issue have agreed. These courts have uniformly held that the legitimacy of managed care in general, and financial incentives in particular, is a question that should be left to the legislature.<sup>194</sup> Although there is a lot of debate about regulating financial incentives, Congress and many state legislatures currently allow them.<sup>195</sup> Some states go beyond merely allowing them by explicitly encouraging such incentives.<sup>196</sup> As long as laws allow financial incentives, courts will be putting physicians in an untenable position if they prohibit physicians from considering them. While a plaintiff might be able to argue that these payment arrangements must be disclosed, they will have a hard time arguing that such arrangements, by themselves, constitute a breach

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193. The other fiduciary duty that courts have identified is the duty of confidentiality. This duty, while important, is not relevant to this article.

194. See, e.g., *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392, 394 (Ct. App. 1979) (dismissing plaintiff's claim that HMO's financial incentives were fraudulent by noting that financial incentives are authorized by federal Health Maintenance Organization Act); *BUSH v. DAKE*, No. 86-25767 NM-2 (Circuit Court of Saginaw County, Michigan, 1989), reprinted in Furrow et al., *supra* note 101, at 719, 721 (holding that it is for the Legislature, not court, to say whether HMO system of financial incentives represents sound public policy).

195. See, e.g., 42 U.S.C. § 300e(c)(2) (1994) (stating that health maintenance organizations may make arrangements with physicians and other providers to assume all or part of the financial risk of providing medical care to members); NEV. REV. STAT. § 695G.040 (1998) (defining managed care as a system which encourages efficient use of health care services by, among other techniques, offering financial incentives for effective use of health care services); MD. CODE ANN., HEALTH-GEN. II § 19-701(f)(5) (1997) (allowing HMOs to pay physicians on a capitated basis, and to provide physicians with an effective incentive to avoid unnecessary inpatient use).

196. See generally CAL. HEALTH & SAFETY CODE § 1342(d) (West 1990) (stating that the intent of the Legislature in authorizing HMOs was to "assure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers").

of fiduciary duty.<sup>197</sup>

Finally, breach of fiduciary duty claims should be limited to nondisclosure because society simply does not expect physicians to display an undivided loyalty to their patients. For example, although a physician generally has a duty to keep a patient's medical information confidential, that duty must give way if the patient presents a serious threat of violence to others.<sup>198</sup> Triage presents another example of society's expectation that physicians must sometimes consider things other than their patients' best interests.<sup>199</sup> In addition, many commentators argue that encouraging physicians to consider the financial ramifications of their medical decisions is a step to be applauded rather than prohibited.<sup>200</sup>

Whether you believe in universal health care or making American businesses more competitive, most people can probably agree that keeping health care costs down is a worthy goal. And many commentators believe that financial incentives are one of the most effective ways to control health care costs by "ensuring that those who make the spending decisions will bear the economic consequences of their actions."<sup>201</sup> While individual patients may be better off under the old fee-for-service system, society as a whole is better off when physicians are encouraged to provide health care more economically.

Ironically, many people also believe that financial incentives are one of the more benign managed care techniques.<sup>202</sup> For example, one prevalent alternative to using financial incentives is to require preapproval for all tests, referrals, and inpatient or outpatient procedures. This approval requirement is known as prospective utilization review.<sup>203</sup>

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197. While such arrangements, by themselves, should not constitute a breach of fiduciary duty, when they actually cause a physician to provide substandard care, the plaintiff should be able to recover both compensatory and punitive damages.

198. See *Tarasoff v. Regents of the Univ.*, 551 P.2d 334, 340 (Cal. 1976).

199. The term triage refers to the screening of patients to determine who should be treated first in times when medical resources are scarce. See GERALD R. WINSLOW, *TRIAGE AND JUSTICE* 1 (1982). Often justified by the utilitarian maxim of doing the most good for the greatest number, triage usually involves separating patients into three groups: those who have little hope of survival; those who will survive without treatment; and those who need treatment in order to survive. See *id.* at 1-11. Although triage has its roots in military medicine, it has spread to mass disaster and emergency medicine. See *id.* at 1, 12. More recently, the concept of triage has been used to allocate life-saving medical technologies which are scarce, expensive, or both. See *id.* at 18-20.

200. See authorities cited *supra* notes 22 and 23.

201. E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment*, 1 WIDENER L. SYMP. J. 89, 90 (1996).

202. See, e.g., Frances H. Miller, *Capitation & Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma?*, 6 HEALTH MATRIX 89, 90-91 (1996) (noting many extol capitation as means of restoring clinical autonomy to physicians).

203. See FURROW ET AL., *supra* note 101, at 321-23. Utilization review refers to the process of evaluating the necessity and appropriateness of medical care. See *id.* at 321.

Utilization review is usually performed by health plan employees.<sup>204</sup> They rarely see the patient, and instead base their decisions on the physician's description of the problem and the application of a preestablished, and sometimes inflexible, set of criteria.<sup>205</sup> Capitated physicians, on the other hand, are often able to make treatment decisions without HMO approval. Because of this, many champion capitation as a way to get treatment decisions out of the hands of bureaucrats and back into the hands of physicians.<sup>206</sup> If you could choose whether treatment decisions would be made by your own physician, financially incentivized though she may be, or by a health plan's utilization reviewer, who would you pick?

## V. IS DISCLOSURE ENOUGH?

*Knowledge is power.*

—Francis Bacon<sup>207</sup>

In the preceding section, I argued that courts should use fiduciary law to compel physicians to disclose financial incentives which could effect their professional judgment. In this section, I discuss both the limits of disclosure and its benefits.

### A. *Limits of Disclosure*

Compelling the disclosure of financial incentives will not solve all of the problems that such incentives can cause. To a patient whose only

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Utilization review can be performed by health care purchasers (i.e., employers), third-party payors, health care organizations, or independent utilization reviewer organizations that contract with these entities. *See id.* at 321-22. Utilization review can be done before treatment is performed, while treatment is being performed, or after treatment is performed. *See id.* at 322.

204. Requests are usually reviewed by nurses first, but denials must be referred to physicians. *See id.* at 322-23.

205. *See id.* at 321-23.

206. *But see* Miller, *supra* note 202, at 97-99 (noting capitation's potential for increasing physicians' autonomy about treatment decisions, but arguing that this potential can easily disappear if contracts with HMO impose other restrictions).

207. JOHN BARTLETT, FAMILIAR QUOTATIONS 158 (Justin Kaplan ed., 16th ed. 1992).

access to health care is through her HMO, disclosure might seem thoroughly inadequate. After all, what options does such a patient have in the face of disclosure? Recall the Jane Doe hypothetical. Assume that Doe's doctor had told her how capitation worked when he told her that she didn't need additional tests. What could Doe have done with this information? According to the terms of her plan, all of her primary care had to be provided, approved, or referred by her primary care physician. Thus, unless her primary care physician approved it, the plan would probably not pay for a second opinion from a different physician. And even if the plan allowed her to pick a new primary care physician, all primary care physicians face the same financial incentive to withhold treatment.

Doe's other alternative would have been to use her own money to get a second opinion from a neutral, non-plan physician; to see a specialist; or to get some diagnostic tests. Doe's husband, you will recall, claims that he and his wife would have gladly paid the cost of the \$250 x-ray that eventually diagnosed her cancer. While this would be an option for some, many people could not afford to pay for a \$250 test on their own. Thus, the disclosure remedy will admittedly be more helpful to those who can afford to pay for some of their own medical care.<sup>208</sup>

Another problem with disclosure is its potential to weaken the doctor-patient relationship. Most doctors do put their patients' best interests ahead of their own financial interests. But if they are forced to disclose how they are paid by the HMO, their patients might become suspicious about the physician's recommendations. Instead of seeing their doctors as patient advocates, patients could start seeing their doctors as adversaries. Since trust and confidence are so crucial to the doctor-patient relationship, disclosure could end up doing more harm than good. It would be ironic if a remedy designed to stop the erosion of the physician-patient relationship actually ended up hastening it.

Finally, many of those who agree that disclosure is an appropriate remedy believe that it should come from the HMO rather than the physician.<sup>209</sup> While there is certainly merit to this view, compelling

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208. See, e.g., Woolsey, *supra* note 101, at 1 (recounting the story of a woman who raised money through a nationwide fund-raising campaign to pay for a bone marrow transplant after her HMO refused to pay for the "experimental" procedure).

209. See, e.g., Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 351-52 (1996) (noting that financial incentives should be disclosed to potential subscribers before they pick their health plans); AMA, *Ethical Issues in Managed Care*, *supra* note 68, at 335 (recommending that plan administrators disclose financial incentives to patients). Note that several states are considering bills that would require HMOs to disclose financial incentives. See, e.g., H.F. 2327, 80th Reg. Sess. § 2(1)-(2)(a) (Minn. 1998) (requiring HMOs to disclose financial incentives to enrollees); A.B.

HMO disclosure is complicated by the Employee Retirement Income Security Act (ERISA).<sup>210</sup> ERISA was enacted to protect employee pension and health care plans.<sup>211</sup> ERISA preempts all state law claims that "relate to" such plans.<sup>212</sup> And although ERISA explicitly imposes fiduciary duties on plans,<sup>213</sup> the remedies for breach are meager.<sup>214</sup> These meager remedies make it unlikely that ERISA will prove very effective in compelling HMOs to disclose financial incentives.

In addition to these meager remedies, courts are split over whether beneficiaries can sue health plans for failing to disclose financial incentives. In *Shea v. Esensten*,<sup>215</sup> for example, the Eighth Circuit held that an HMO can be held liable for breach of ERISA's fiduciary duties by failing to disclose financial incentives.<sup>216</sup> In contrast, in *Weiss v. Cigna Healthcare, Inc.*,<sup>217</sup> the United States District Court for the Southern District of New York held that, while an HMO cannot deceive or mislead plan beneficiaries, an HMO has no duty to disclose financial incentives.<sup>218</sup> Until either the Supreme Court or Congress resolves this split, HMO disclosure is unlikely.<sup>219</sup>

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2668, 207th Leg., 2d Ann. Sess. § 7(c)(2) (N.J. 1997) (same); H.B. 520, 100th Gen. Ass. § 11(b) (Tenn. 1997) (same).

210. ERISA is codified at 29 U.S.C. § 1001 et seq. (1994).

211. See 29 U.S.C. § 1001(a)-(c).

212. 29 U.S.C. § 1144(a). For an excellent discussion of the scope of ERISA's preemption in suits against HMOs and of how HMOs have been able to hide behind preemption to avoid liability for damages, see Susan O. Scheutrow, *A Framework for Analysis of ERISA Preemption in Suits Against Health Plans and a Call for Reform*, 11 J.L. & HEALTH 195 (1996-97).

213. See 29 U.S.C. § 1104(a)(1) (requiring plan fiduciaries to discharge duties solely in interests of beneficiaries).

214. See 29 U.S.C. § 1132(a). Remedies are generally limited to recovery of benefits due under the plan, or injunctive or declaratory relief. See *id.* § 1132(a)(1)(B). Thus, in the Jane Doe hypothetical, if Doe wanted to sue her HMO, her recovery would be limited to the cost of the additional tests she claims her physician dragged his feet on ordering. The barium enema x-ray that eventually diagnosed her cancer cost \$250. This might be all Doe would be entitled to recover under ERISA.

215. 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 297 (1997).

216. *Id.* at 629.

217. 972 F. Supp. 748 (S.D.N.Y. 1997).

218. See *id.* at 755.

219. There are currently several bills pending in Congress that address this issue. See, e.g., H.R. 1222, 105th Cong. § 713(h)(2) (1997) (requiring managed care plans to "inform enrollees of the financial arrangements between the plan or issuer and participating providers . . . if those arrangements include incentives or bonuses for restriction of services"); H.R. 586, 105th Cong. §§ 2(a)(1), 4(4)(A) (1997) (prohibiting health plans from restricting physicians from disclosing financial incentives to patients); S. 449, 105th Cong. §§ 2(a)(1), 3(4)(A) (1997) (same).

Even if HMO disclosure were required, there is still a need for physician disclosure. HMO disclosure would undoubtedly be made in the plan booklet—a document given to HMO members that explains the terms of the plan. It is doubtful that many people read this document very carefully, if at all. Therefore, personal disclosure by a patient's physician is a more effective way to make sure that patients know about financial incentives.

### *B. Benefits of Disclosure*

Despite the limits of disclosure, it has many potential benefits as well. For example, disclosure cures what some critics see as the most troubling aspect of financial incentives—their covert nature.<sup>220</sup> The covert nature of financial incentives is problematic for three reasons. First, failing to disclose these incentives is misleading to patients, who trust that physicians are acting in their best interests. Second, the hidden character of financial incentives makes it difficult for patients to link them with adverse outcomes.<sup>221</sup> Jane Doe's husband was lucky; he found out how his wife's physician was paid and will thus be able to raise this issue in a lawsuit. But there are probably many others who are not so lucky. These patients never think their adverse outcomes might have been caused by financial incentives because they don't know about them. Finally, as long as they remain hidden, financial incentives will be difficult to monitor and respond to. Disclosure could lead to the regulation or prohibition of the most offensive forms of financial incentives.<sup>222</sup>

Disclosure would also encourage patients to take a more proactive approach to their health. For example, knowledge of financial incentives might make patients question or challenge their doctors' recommendations or insist on getting more information about their diagnosis. In some cases, questioning by a patient might be the only nudge a doctor needs. It is probably easier for a doctor to tell a patient, "I don't think you need this test," when the doctor knows the patient is ignorant of the fact that the costs of the test come out of the doctor's own pocket. If the patient knows about the financial incentives, it might be much more difficult for the doctor to deny care. Let's change the Jane Doe hypothetical, to see how disclosure might have affected the

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220. See McGraw, *supra* note 91, at 1836.

221. See *id.*

222. See Morreim, *supra* note 201, at 130 (arguing that the most offensive incentive schemes are likely to disappear if disclosed); see also authorities cited *supra* note 26 (listing commentators who believe that certain financial incentives have a greater potential for abuse than others).

situation.

Jane Doe's doctor feels a palpable mass during a pelvic exam. He performs an ultrasound, but the results are inconclusive. He tells Doe the mass is "probably" a fibroid tumor, and that she shouldn't worry about it. Jane, knowing that her doctor is financially rewarded for keeping costs down, is not satisfied. She asks what additional tests are available to establish that the mass really is a fibroid tumor. She also asks what else a mass in the pelvic area could be and what tests are available to diagnose these other possibilities. Doe's doctor tells her that such a mass might indicate colon cancer, but that colon cancer is very unlikely. Doe asks why, and the doctor explains that colon cancer is extremely rare in those under forty with no family history of colon cancer. He also explains that she doesn't have the usual symptoms of colon cancer. Doe asks what those symptoms are, and the doctor mentions rectal bleeding. Doe has been experiencing rectal bleeding. She thought she had mentioned this at the beginning of the appointment, but now she reiterates it. She tells her doctor that she would really feel better if she could have the mass checked out more thoroughly. Since their discussion has unearthed a symptom the doctor wasn't aware of, and since he feels a little awkward that Doe knows he bears the costs of the test, he agrees. Tests are performed; the cancer is discovered earlier, and Doe survives.

This is, obviously, a fairy-tale happy ending, and I am not suggesting that disclosure will always—or even often—lead to a similar result. However, the hypothetical does show how disclosure could make patients more proactive about their health and encourage communication between patient and physician. Doe's questioning not only prompted her doctor to reconsider his initial decision that more tests were unnecessary, but it also highlighted symptoms that the doctor was not focused on. Doe's knowledge of financial incentives made her a more intelligent and informed health care consumer.

In addition to encouraging patients to challenge their doctors, disclosure might encourage patients to challenge their HMOs. Most HMOs, at least informally, allow patients to appeal denials of care. Some states even require detailed appeals procedures.<sup>223</sup> When financial

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223. See CAL. HEALTH & SAFETY CODE § 1368-1368.01 (Deering Supp. 1997) (requiring HMOs to establish grievance procedures and resolve grievances within 30 days, or within five days in cases involving imminent and serious threats to patient health).

incentives are hidden, patients might not even suspect that care is being denied when a doctor says, "you don't need to see a specialist." Disclosure would increase patients' access to HMOs' appeals procedures.

Finally, disclosure would help patients become more meaningfully involved in the debate over managed care by making them more aware of how much health care costs. From the physician's perspective, managed care is rapidly eliminating the incentives to overtreat that were built into the fee-for-service system. However, managed care has done little to change the patient's incentives. Many HMOs have actually eliminated deductibles and coinsurance, and many HMO patients never see a physician or hospital bill. Both developments have made patients more isolated than ever from the costs of health care. Since patients don't pay for the costs of office visits, diagnostic tests, or surgical procedures, they have no reason to consider whether their health care is being provided efficiently.<sup>224</sup> And although "patients bear little of the increased costs associated with high consumption of health care," they stand to reap all the benefits.<sup>225</sup> As one commentator has noted, "patients' economic insulation has tended to breed a striking naivete about the economics of health care, and an entitlement attitude demanding an unlimited right to every possible benefit, regardless of the cost or their own [in]ability to pay for it."<sup>226</sup>

Most people support managed care's goal of keeping health care costs down. But as one commentator has noted, "[t]he trick . . . is to devise a system wherein the incentives . . . reinforce delivery of the kind of care this country wants, at the price we are willing to pay for it."<sup>227</sup> It is understandable that patients feel they are entitled to the best and most aggressive health care money can buy when they do not directly bear the costs of health care and have little idea of how high those costs can be. In order for society to figure out how much it is willing to pay for health care, patients need to have a better idea of how much it actually costs.

For example, assume a seriously ill patient is given two treatment options, A and B. Treatment A has a 95% chance of success and causes adverse, but non-lethal, reactions in 15% of all users. Treatment B has a 95.7% chance of success and causes adverse, but non-lethal, reactions in

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224. See Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 535 (1968) (noting that "the response of seeking more medical care with insurance than in its absence is a result not of moral perfidy, but of rational economic behavior").

225. Rex O'Neal, *Safe Harbor for Health Care Cost Containment*, 43 STAN. L. REV. 399, 400 (1991).

226. Morreim, *supra* note 201, at 97.

227. Frances H. Miller, *Forword: The Promise and Problems of Capitation*, 22 AM. J.L. & MED. 167, 172 (1996).



3% of all users. Given only this information, most patients would rationally choose option B. It has a slightly higher success rate and fewer side effects. If patients were also told, however, that treatment A costs \$750 while treatment B costs \$10,000, patients might reconsider. At the very least, patients would be forced to consider whether a slight increase in the chance of success is worth the extra \$9,250. A heightened awareness that this is the type of choice that doctors and managed care plans face every day would encourage patients to get involved in the debate over how our health care dollars should be spent.

### CONCLUSION

Managed care's goal of reducing health care costs is an exemplary one. But achieving this goal will not come without costs to both patients and physicians. Under the old fee-for-service system, sick and anxious patients who wanted the best care that money could buy could usually find physicians who were happy to provide it and insurers who were willing to pay. When insurers were unwilling to pay, physicians had every incentive to advocate aggressively for their patients. Managed care has cut down on the ability of patients to decide for themselves whether to see a specialist or undergo a particular procedure and has placed these decisions in the hands of physician-gatekeepers. Because of this gatekeeper role, patients are beginning to see physicians as their adversaries rather than their advocates.

Managed care has also affected physicians by forcing them to explicitly consider, or personally bear, the costs of their treatment decisions. Where physicians under the fee-for-service system were rewarded for practicing defensive medicine, physicians under managed care are rewarded for practicing cost-effective medicine. While this shift in the way health care is delivered probably benefits society overall, it can nonetheless prove detrimental to individual patients.

This Article has argued that courts should recognize that the physician-patient relationship is a fiduciary one and that physicians have a fiduciary duty to disclose managed care financial incentives to their patients. When a physician breaches this duty, the physician should be liable to the patient for all damages caused by the breach or for the amount of the physician's income that is attributable to the undisclosed incentives. Although disclosure will not return the physician-patient relationship to the way it was before the advent of managed care, it will

empower patients by giving them the information they need to become their own advocates.